Maternal and Child Health Services
Title V Block Grant

State Narrative for Oklahoma

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Assurances Non-Construction Programs, Form 424B, is signed by the Oklahoma Commissioner of Health. The Certifications regarding debarment and suspension, drug-free workplace requirements, lobbying, Program Fraud Civil Remedies Act (PFCR), and environmental tobacco smoke are also signed by the Oklahoma Commissioner of Health. The original signed documents are kept in a central folder in the Maternal and Child Health Service (MCH) at the Oklahoma State Department of Health. Copies are available upon request by contacting MCH at (405)271-4480 or PaulaW@health.ok.gov.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Input into the Title V block grant, needs assessment, activities, and programs is sought on a routine basis. The Oklahoma Title V Program engages families, consumers, public and private sector organizations, and other stakeholders at the state and community levels in continuous processes to assure the needs of the maternal and child health population are identified and addressed.

For the Title V 2011-2015 Needs Assessment, public input was sought in a variety of ways. On March 30, 2009, a press release was sent out announcing the State's intent to open up an anonymous, online survey about the health needs for the maternal and child health (MCH) population in Oklahoma. The press release was picked up by several newspapers and newsletters. The press release explained Title V, its funding source, its mission, and directed the potential respondents about where and how to access the survey. Postcards were handed out at various meetings and conferences announcing the survey and encouraging participation. Approximately 700 individuals representing stakeholders from various professions, agencies, programs, and consumers participated in the online survey. At the completion of the survey, participants were invited to return to the website for a summary of the findings. Refer to the Oklahoma Title V 2011-2015 Needs Assessment Appendix A for a copy of the survey, and Appendix B for a summary of the findings.

Information from the online surveys was used in the identification of priority needs for all three Title V population groups. In addition, two task forces, the Perinatal Advisory Task Force (PATF), and the Child Health Advisory Task Force (CHATF), were presented the top 10 priorities selected from a review of public input and data. These task forces assisted the Title V program in narrowing the focus to the top three-to-five priority needs for each population group. Refer to

Appendix D of the Oklahoma Title V 2011-2015 Needs Assessment for a flow chart on stakeholder involvement in the Title V Needs Assessment process.

Several Title V funded programs in MCH and Children with Special Health Care Needs (CSHCN) have mechanisms and advisory groups to facilitate public, family, and consumer input addressing specific issues or projects. For example, focus groups are used to gain input into policies and service. The Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) and The Oklahoma Toddler Survey (TOTS) have a joint Steering Committee which consists of a diverse group of interagency professionals and individuals who offer input on survey methods, survey questions, incentives, and analysis projects. In addition, the First Grade Health Survey, exclusively Title V funded, relies on individuals with experience in children's health, education, as well as family input, to craft and revise the survey questionnaire. Customer satisfaction surveys are conducted by county health departments and contractors to explore ways to better serve clients. These surveys are also on the MCH webpage for direct submission to MCH. CSHCN receives input at monthly meetings with the Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs) State Interagency Coordinating Council which consists of professionals and family members from numerous agencies that provide services to children with special needs. CSHCN also receives input from several parent groups at various conferences held throughout the year, as well as from surveys and face-to-face interaction. These are but a few examples of how the Oklahoma Title V program incorporates public input into ongoing activities and programs.

Oklahoma provides access for public input to the MCH Title V Block Grant throughout the year via an active link to the federal Maternal and Child Health Bureau (MCHB), Title V Information System (TVIS) website. This active link titled, Public Input Sought For Maternal and Child Health Service Title V Block Grant, is found at the bottom of the MCH web page, www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/, on the Oklahoma State Department of Health's (OSDH) website. Information on how the public may forward input on the grant is provided on the MCH web page directly under the active link. The Children with Special Health Care Needs Program (CSHCN), Oklahoma Department of Human Services (OKDHS), has a link to the OSDH MCH web page on the CSHCN web page, http://www.okdhs.org/programsandservices/health/cshcn/ on the OKDHS website. Hard copies of the MCH Title V Block Grant are also provided on request to MCH at (405) 271-4480 or via e-mail to PaulaW@health.ok.gov.

Public input via e-mail, letters, and telephone calls is received intermittently throughout the year. MCH and CSHCN use this public input in evaluation, planning, and development of policies, procedures, and services that are reported and described in the MCH Title V Block Grant annual report and application for submission to the MCHB.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Title V Needs Assessment for the years 2011-2015 consisted of an 18-month process that culminated in the setting of ten state priorities as focus areas to improve the health of pregnant women, mothers, infants, children, and children with special health care needs. Through the continuous and ongoing collection, extensive research, evaluation, and analysis of all available data and data sources, along with the attendance of regularly scheduled meetings, organized focus groups, and survey input, the Title V program (MCH and CSHCN) and the Oklahoma Family Network (OFN) were able to formulate and conclude how best to serve all aspects of Oklahoma's MCH population, taking into account the state's current and anticipated economic climate and system capacity. Over 700 community members, social service and public health professionals, family members, and health care providers participated in the process which began with open-ended comments in a survey and became increasingly more focused as time and efforts progressed.

The process for priority selection for this block grant application differed significantly from the one used for the program years, 2006-2010. Community and family involvement improved significantly with the development of the online survey tools which were widely disseminated through partner networks (See Appendix G of the Title V Needs Assessment). The use of a priority matrix enabled staff to review comments, obtain community input, determine the feasibility of impact, and review data trends in the prioritization of issues. The involvement of task force groups, who specialized in each area of MCH, enabled the MCH, CSHCN, and OFN to identify the top three to five priorities for Parts A, B, and C utilizing a more inclusive methodology. Agency capacity to address the priorities, performance measures, indicators, and outcome measures has changed somewhat since the previous application period. The greatest change has been reduction in funding due to the economic downturn. This is presenting challenges, yet these challenges are also being viewed as opportunities.

The chosen priorities for the federal fiscal years 2011-2015 are a realignment of the previous needs assessment along with a shift in focus towards reducing infant mortality rates within the state. Several of the state priorities affect all MCH population groups and are therefore considered overarching priority needs: access to care, tobacco prevention, obesity, and preconception care. By enhancing and targeting efforts in these areas, it is theorized that the health among all MCH population groups will be positively impacted. Those more specific state priorities, unintended pregnancies, infant safe sleep, infant mortality, motor vehicle injury, child care for families with CSHCN, and transition to adulthood for CSHCN are targeted more towards groups within the MCH overall population; however, some, such as reducing unintended pregnancy, and infant mortality rates have the potential to positively impact all three population groups. Within all of the chosen priorities reducing health disparities is sentinel to Oklahoma's MCH policy and practice.

III. State Overview

A. Overview

Oklahoma has a diverse geography with a quarter of the state covered by forests and includes four mountain ranges: the Arbuckle, Ouachita, the Ozark Plateau, and the Wichita. Oklahoma is one of only four states with more than 10 distinct ecological regions. To the west, the state has semi-arid plains, while in the central portion of the state transitional prairies and woodlands give way to the Ozark and Ouachita Mountains which stretch out in an eastward direction towards the Arkansas border. The diversity of the geography is matched by the diversity of the state's people and their life experiences. Health care access and availability, transportation options, and employment opportunities are not always consistent and vary by region of the state.

Demographics

In 2009, Oklahoma had an estimated 3,687,050 residents, an increase of 43,025 (1.1%) from 2008, and ranked as the 28th most populous state. The state's population has increased each year since the year 2000 Census was conducted. Since that time, the population has grown in absolute terms by 236,396 representing relative growth of 6.9 percent. With its 77 counties, the state spans some 69,898 square miles, ranking 20th in land area, with approximately 53 persons per square mile, and ranking 36th among all U.S. states in population density. Roughly positioned in the center of the 48 contiguous states, Oklahoma is bordered by six states: Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas. Oklahoma, characterized mainly as a rural state, has three larger cities. The largest of which is Oklahoma City, the state's centrally located capitol city, home to 551,789 residents (15.1%). Approximately 100 miles to the northeast is Tulsa, a city that accounts for 385,635 (10.6%) of the state's population. Nearly 90 miles to the southwest along Interstate 44 is the city of Lawton, which has a total population of 90,091, or 2.5 percent of the state's total.

Nearly 60 percent of the Oklahoma population resides in the metropolitan statistical areas of Oklahoma City (1,189,529; 32.9%) and Tulsa (903,868; 25.0%). A much smaller percentage of the Oklahoma population lives in the metropolitan statistical area of Lawton (112,653, 3.1%). The remainder of Oklahomans resides in rural locales, smaller cities, and towns beyond the periphery of the three metropolitan centers. Recent years have seen population shifts to the more urban areas.

Approximately, 25 percent of the Oklahoma population is under 18 years of age. Persons aged 65 years and older make up 13.5 percent, leaving about 61 percent of the population between the ages of 18 and 64 years. The male-female ratio is roughly 1:1. In 2008, females of childbearing age (e.g., 15-44 years) numbered 722,027, or about 20 percent of the Oklahoma population. The white population makes up 78 percent of the total population, while African American/Black and American Indian/Alaska Native citizens both equal about 8 percent. Less than 2 percent of the population is of Asian descent. As a percentage of the total population, Oklahoma's American Indian/Alaska Native population is about 8 times bigger than the comparable U.S. population. Oklahoma is home to the largest number of federally recognized tribes, 38 American Indian tribal governments with an additional tribe pending federal recognition. The Hispanic or Latino population comprises 7.6 percent of the total Oklahoma population.

Variations exist by race and ethnicity in the primary location of residences. While the white population is spread geographically across the state, the African American population tends to reside in the urban areas of Oklahoma City and Tulsa. The American Indian population has greater presence in the northeast quadrant of the state, a legacy of the U.S. federal government tribe relocation programs of the 19th century. Initially, the Hispanic population growth was isolated in many of the rural farming communities of the state, particularly in the south and southwest regions as well as the panhandle of the state; however, more recent trends show that this population has begun to merge itself into the larger metropolitan areas.

Oklahoma's per capita personal income was $35,268 in 2009, ranking 34th among all states, and representing about 90% of the national value. For the general population, nearly 16 percent of Oklahomans live below the federal poverty level. The poverty rate rises when considering only females aged 15-44, the principal childbearing age group. For this group, 1 in 5 live at or below 100% of the federal poverty level. For children aged 24 years and younger, 24 percent are at poverty status. Oklahoma is a poor state and despite relatively low unemployment rates, the state estimates that 14 percent of all Oklahomans do not have health coverage. In 2008, 12.6 percent of children under the age of 19 years were reported to be without health care coverage.

Economy

Oklahoma is a major producer of natural gas, oil, and agricultural products. The state's economic base relies on aviation, energy, telecommunications, and biotechnology. The two major metropolitan centers, Oklahoma City and Tulsa, serve as the primary economic anchors for the state. The top employers within the state are the State of Oklahoma (38,000), Tinker Air Force Base (24,000), and the U.S. Postal Service (8,700). From the health care sector, Integris Health (6,200), OU Medical Center (3,250), Mercy Health System of Oklahoma (2,426), and SSM Health Care of Oklahoma (2,355) contribute a sizable number of jobs to the Oklahoma economy.

Oklahoma's growth domestic product (GDP), the output of all goods and services produced by the economy, totaled $146.4 billion in 2008, up 2.7 percent from 2007 in real dollar terms. As a percentage of the GDP, industry share in the Oklahoma economy was led by trade, transportation, and utilities at 17.6 percent, followed by government at 15.7 percent. Mining, financial services, and manufacturing represented 14.3 percent, 12.0 percent, and 10.8 percent, respectively. Gaming (lotteries and casinos) has become a significant contributor to the Oklahoma economy. Behind California, Oklahoma now has the second largest gaming revenue from American Indian gaming ventures. In 2008, Oklahoma tribal casinos brought in almost $2.9 billion in gaming revenue, an 18 percent growth from the previous year. Tribal gaming fees have contributed $107.5 million to the state treasury for fiscal year 2010, with the forecast suggesting the amount to rise to $120 million by fiscal year end. Most of the tribal gaming fees are directed towards funding for public schools, but $250,000 per year is provided to the Oklahoma Department of Mental Health and Substance Abuse Services for remediation of gambling problems. As of June 2010, there were 110 casinos operating in the state.

In general, Oklahoma's economy tends to follow broad national economic trends. According to the National Bureau of Economic Research (NBER), the U.S. economy entered a recession in December 2007. The U.S. economy declined 5.4 percent in the 4th quarter of 2008 and 6.4 percent in the 1st quarter of 2009; these economic contractions represent the largest declines experienced since the early 1980s. More recent data show the national economy expanding with positive growth of 5.6 percent and 3.0 percent in the 4th quarter of 2009 and the 1st quarter of 2010, respectively. State data for GDP lag that of the national economy; therefore it is often not a timely indicator of the current economic conditions. However, it can provide valuable signals of the state's economic growth.

Preliminary data from the U.S. Bureau of Labor Statistics for April 2010 show the Oklahoma unemployment rate at 6.6 percent of the available labor force (1,779,708). The unemployment rate is down from a high of 6.9 percent reported in October 2009. As a percentage, Oklahoma's unemployed labor force is smaller relative to the U.S. In April 2010, there were 608,000 first time claimants for unemployed benefits. Total non-farm employment represents approximately 92 percent of Oklahoma employment with the largest contributor being government jobs, 22 percent or approximately 335,800. Employment in "trade, transportation, and utilities" and "education and health services" represents 18.1 percent (276,300) and 13.6 percent (206,500) of Oklahoma jobs, respectively. Overall, non-farm employment over the 12-month period ending in April 2010 showed a decline of 1.7 percent, a pace that has decelerated over the preceding six months. Oklahoma's two largest counties, Oklahoma and Tulsa, account for roughly 50 percent of the state's total employment. Job loss for 2008-2009 has hit industries relatively hard with all sectors except two (Government and Education and Health Services) experiencing a loss in the number

of jobs. The heaviest hit industry was manufacturing with more than 20,000 jobs lost during the period. Professional and business services lost another 17,300 positions in the Oklahoma economy. Government and Education and Health Services added 9,200 and 4,000 jobs, respectively.

Budgetary Concerns

Oklahoma had been slower to feel the impact of the national economic situation due to oil and natural gas prices. With the drop in market prices for those energy products, the state has since been faced with budget shortfalls that have approached 18.5 percent of its general fund budget. To end state fiscal year (SFY) 2009, state agencies received a 1.4 percent budgetary cut in the June 2009. On July 1, 2009, SFY2010 began with state funding down $612 million from SFY2009. A state fiscal budget of $7.2 billion was approved, an amount similar to previous state budgets, yet, with an important difference; $631 million of the $7.2 billion were federal stimulus funds. For SFY2010, state budgetary shortfalls were closed through a combination of spending cuts and use of federal stimulus dollars.

In response to the state's budgetary situation, the Commissioner of Health, with support of the Board of Health, made the decision in early SFY2010 to reduce the Oklahoma State Department of Health's state budgets by 7.5%. With this proactive decision, the Oklahoma State Department of Health (OSDH) has been able to move forward with operations and not react monthly to news of continuing state budget shortfalls.

For SFY2011, the governor and legislative leaders agreed on a $6.8 billion budget. Budget analysts and negotiators had $1.2 billion less to work with than was originally appropriated. To address the shortfall, leaders proposed a balanced budget (required by law) using a series of targeted agency cuts, reserve and stimulus funds, cost recovery methods, and other unnamed savings and efficiencies across state government. State agencies again received cuts in state appropriations. The level of cuts differed among the state agencies with the OSDH receiving a 7.5 percent reduction. With this 7.5 percent reduction, combined with SFY 2010 cutbacks, the agency was subject to an equivalent of a 15 percent decrease in budget funds for the two year period. In addition, the OSDH faces approximately $3 million in additional costs each year due to increasing health care costs and benefits for the current workforce. With the response to a Voluntary Out Benefit Offers (VOBO) by retirement eligible staff, some pressures on agency funds have been relieved. Senior leadership of the agency does not anticipate furloughs of the workforce in SFY2011 as other state agencies have had to do.

The downside of the reduction in budget funds and staffing is the elimination of services to the Oklahoma population. Budget difficulties have led to decrease in services to residents, including those who are most vulnerable. Current estimates indicate that 11,000 individuals and families have been affected by the agency budget shortfall. Another consideration with the loss of agency staff to retirement is the concomitant loss of years of experience. Of the 354 eligible for the VOBO, 62 people elected to take early retirement. These individuals represented nearly 1,800 years of service to the state of Oklahoma.

Public Health Workforce

The Oklahoma's Health Care Industry Workforce 2006 Report examined 2005 health care worker vacancies and projected shortages of 1) nurses, 2) lab technicians, 3) physical therapists, 4) surgical technologists, 5) occupational therapists, 6) pharmacists, and 7) radiology and respiratory professionals for 2012. In 2008, a follow-up study, conducted by the Oklahoma Healthcare Workforce Center, identified there were high vacancy rates and predicted shortage concerns for emergency medical technicians and chemical dependency counselors. National studies have shown that the public health workforce has: shortages of key public health personnel (e.g., epidemiologists and public health nurses); trends in insufficient number of experienced public health workers due to many approaching retirement age; inadequate incentives for recruitment and retention of qualified professionals; and insufficient preparation and orientation of students by professional education programs to the public health system.

The United Health Foundation report for 2009 ranked Oklahoma 49th in the nation for primary care physicians per 100,000 population, with five rural counties having only one physician providing primary care services. Migration of rural residents to the metropolitan centers has had a negative impact upon the availability of health care providers. Diminishing populations, rising medical liability costs, and low Medicaid reimbursement rates have influenced physicians to relocate or to restrict their practices. The net result has created a number of significant geographic gaps in obstetric and pediatric medical care across the state.

Awareness of these findings and what they foreshadow led to the development of the public health workforce development workgroup of the Oklahoma Health Improvement Plan (OHIP). This group seeks as its long-term outcome the creation of a private and public workforce that is well prepared, of sufficient size, and distributed geographically such that the health care needs of Oklahoma's population, rural and urban, can be fully met. The rural demographic of the Oklahoma population, its economic challenges, and the lack of primary care providers require that public health leaders identify new ways to assure that those citizens with need for health services have access to those services.

Government

The government of Oklahoma, modeled on the U.S. federal government, is a constitutional republic with legislative, executive, and judicial branches. Oklahoma has 77 counties, each having local jurisdiction over government functions, and five congressional districts. State officials are elected by plurality voting. The biennial Oklahoma legislature is bicameral (having two legislative chambers), consisting of a Senate and House of Representatives. The Oklahoma Senate has 48 members serving four year terms. Senators serve a staggered term; thus, only half of the senate districts have elections in any election year. The House has 101 members, each holding office for two year terms. Term limits restrict elected officials to a total of 12 cumulative years of service between both legislative branches. The Governor of the state is the principal head of government, serving as the chief officer of the executive branch of government. This office submits the budget and assures the enforcement of state law. Term of office is four years. The judicial branch consists of the Oklahoma Supreme Court, the Oklahoma Court of Criminal Appeals and 77 District Courts, one for each Oklahoma County. Two independent courts, the Court of Impeachment and the Court on the Judiciary, are also included in the makeup of the judiciary branch. Judges sitting on the Supreme Court, the Court of Criminal Appeals, and the Court of Civil Appeals are appointed by the governor upon recommendation of the Judicial Nominating Commission. These judges stand for retention vote on a six year rotating schedule.

Thirty-nine American Indian tribal governments are based in the state of Oklahoma. Each of these tribal governments has limited powers within defined geographic areas. Indian reservations in the conventional sense do not exist in Oklahoma. Tribal governments, recognized by the U.S. as quasi-sovereign, hold land granted by the federal government with limited jurisdiction and no control over state governing bodies. Executive, judicial, and legislative powers of the tribal governments are relevant to tribal members but remain subject to federal authority held by the U.S. Congress.

Voter registration for January 2010 shows that 49 percent of registered Oklahoma voters are registered with the Democratic Party. Republican Party members made up 39 percent of the registered electorate. However, the state is one of the more conservative in the union. Since 1968, the state's electoral votes have gone to the Republican presidential candidate. In 2008, Oklahoma was the only state whose counties voted unanimously for John McCain. The Oklahoma delegation to the U.S. House of Representatives represents five congressional districts with four of the five being registered Republicans. These House representatives are John Sullivan (R-OK1), Dan Boren (D-OK2), Frank Lucas (R-OK3), Tom Cole (R-OK4), and Mary Fallin (R-OK5). The two senators from Oklahoma are Tom Coburn (R) and James Inhofe (R).

The November 2008 election cycle saw for the first time in state history a sweep of both

legislative chambers for the Republican Party. In the Oklahoma 52nd State Legislature 2009-2011, the majority (26) of the seats in the Senate is held by the Republican Party. The Democratic Party holds 22 of the Senate seats. Likewise, in the House, the Republican Party holds the majority, accounting for 62 of the 101 House seats. The Office of Governor is currently held by Brad Henry (D), whose second term will end in January 2011. Term limits bar Governor Henry from seeking reelection in November 2010.

Legislative Update

MCH serves as a resource and provides education to state legislators and their staff prior to and during the legislative session each year to assist in the setting of state policy and procedure (e.g., this year: access to health care, breastfeeding, injury prevention, school health, child welfare). Analyses of bills are accomplished each year during session to identify issues that may present obstacles to improving the health of Oklahoma's maternal and child health population. These written analyses are shared with legislators and their legislative staff by the Commissioner of Health and the Director of the OSDH Office of State and Federal Policy. MCH also participates in state boards, task forces, workgroups and committees during and between sessions per request of members of the state Legislature or as appointed by the Governor. MCH is able to provide to the legislative process the latest in national health care policy and practice; information on national, regional, and state health care issues and practices; and, the most recent available national, regional, and state data for the maternal and child health population.

Another means afforded to MCH each year for involvement in the legislative process is participation in the Oklahoma Legislative Fall Forum. This annual event sponsored by the Oklahoma Institute for Child Advocacy, brings maternal and child advocates from the state, regional, county, and community levels together to focus on MCH health issues and set a legislative agenda.

During the 2010 legislative session, numerous bills were followed closely by OSDH and MCH:
Autism: Senate Bill (SB) 2045 requires insurance companies provide children with autism the same coverage for non-autism-related illnesses, diseases, and injuries that children without autism are provided and states that such coverage does not constitute coverage for autism-related treatments. SB2045 was signed by the governor in April 2010.

Women, Infants and Children Supplemental Nutrition Program (WIC): House Bill (HB) 2775, signed into law by the governor in April 2010, authorizes the OSDH to contract with existing vendors that provide electronic benefit transfer systems to the Oklahoma Department of Human Services to deliver WIC benefits electronically.

Maternal/Infant Care: HB2920 creates the Oklahoma Maternal-Infant Quality Care Act and the Oklahoma Maternal-Infant Quality Care Collaborative until December 2015 to identify and monitor ways to remove barriers to hospitals and providers in providing safe, quality health care for mothers and infants. HB2920 directs the collaborative to submit a report to the governor and legislator each December beginning in 2011. This House bill was approved by the governor in May 2010. SB1817 modifies language related to the treatment of eye diseases in newborns. The bill eliminates language requiring certain medical providers and parents of newborns to provide certain care. Physicians, midwifes and other birth attendants are required to ensure treatment of the eyes of the infant with a prophylactic ophthalmic agent as recommended by the CDC to prevent ophthalmia neonatorum. Under the bill, parents or legal guardian may refuse treatment if it is deemed in the best interest of the child. The health care provider must document refusal and include in newborn's medical file. The Oklahoma State Board of Health is charged with promulgating rules to implement legislation. SB1817 was signed into law in May 2010.

Injury: SB1700 directs school districts to partner with the Oklahoma Secondary School Activities Association to develop the guidelines and forms to guide coaches, athletes, and parents or guardians about the nature and risk of concussions and head injuries. An information sheet on concussion and head injury must be completed and returned to the school district by the youth

athlete and his/her parents before the athlete can return to practice and competition. SB1700 requires that a youth sustaining a concussion or head injury may not return to practice or competition until a licensed health care provider has evaluated and released the athlete. SB1700 was signed into law by the governor in May 2010.

Primary Care: HB1043 creates the Oklahoma Medical Loan Repayment Program to provide educational loan repayment assistance up to $25,000 per year for five years for up to six Oklahoma licensed primary care physicians per year who agree to set up practice in a community approved by the Physician Manpower Training Commission. The bill was amended in the Senate to add qualifications for physicians participating in the loan program. HB1043 was approved by Governor in May 2010.

Nutrition: HB3015, signed into law by the governor in April 2010, modifies the definitions under the Agricultural Linked Deposit Act by including certified "healthy corner stores" under the definition of "eligible agricultural business." This bill requires eligible healthy corner stores to be certified by the Oklahoma Department of Agriculture, Food and Forestry to market locally grown fruits and vegetables and nutritious foods and for which the sale of beer and tobacco products comprise less than 10 percent of gross sales, excluding gasoline and other non-grocery items. The stores must be located in geographic areas considered underserved by grocery outlets meeting these requirements.

Health Care Reform: House Joint Resolution (HJR) 1054 proposed language prohibiting a state resident from being required to obtain or maintain a policy of health insurance coverage, except as required by a court or the Department of Human Services in a case where the individual is named a party in a judicial or administrative proceeding. HJR1054 sought to prohibit law or administrative rules that made Oklahoma residents liable for penalty or fine due to failure to obtain health insurance coverage. The resolution authorized the Senate president pro tempore and the House speaker to hire legal counsel to file a lawsuit against the U.S. Congress, the President and the Secretary of the U.S. Department of Health and Human Services to prevent the provisions of the Patient Protection and Affordable Care Act from taking effect. The Senate failed to override the governor's veto of HJR1054. Senate Joint Resolution (SJR) 0059 proposes a constitutional amendment prohibiting a law from compelling any person, employer, or health care provider from participating in a health care system and allowing a person or employer to pay directly for health care services without being required to pay penalties or fines. SJR0059 prohibits the purchase or sale of health insurance in private health care systems from being prohibited by law or rule. The conference committee report for SJR0059 has been read into the House as of May 2010.

Pregnancy Resource Centers: Senate Resolution (SR) 0082 expressed support for pregnancy resource centers, encourages their support and expresses disapproval for opposition to these centers. Resolution went to the Office of the Secretary of State in February 2010.

Abortion: SB1890 prohibits any person, knowingly or recklessly, from performing or attempting to perform an abortion with knowledge that the pregnant female is seeking an abortion solely on the account of the sex of the unborn child. The governor signed SB1890 in April 2010. SB1891 creates the Freedom of Conscience Act, which prohibits an employer from discriminating against an employee by refusing to accommodate the employee's religious views on abortion, uses of cells derived from human embryo, and other experimental or medical procedures defined in the bill. SB1891 states that a health care facility is not required to admit a patient or use its facilities for any of these defined acts. This bill was signed by the governor in April 2010. SB1902 prohibits a person from knowingly or recklessly giving, selling, dispensing, administering, prescribing, or providing RU-486 for the purpose of inducing an abortion in a pregnant female, unless that person is a physician meeting certain qualifications. SB1902 provides requirements for the dispensing of RU-486. This bill was signed by governor in April 2010. HB2656 prohibits pregnant women and their families from seeking legal damages if physicians knowingly or negligently withhold information or provided information to them about their pregnancy. The state

representative who authored the bill said the measure prevents a doctor from being sued based on the opinion after birth that a child would have been better off if s/he would have been aborted. Governor Henry vetoed this bill. The veto was overturned by a vote in the House of 84-12 and by a Senate vote of 36-12. HB2656 was filed with Secretary of State in April 2010. HB2780 requires an abortion provider to perform an obstetric ultrasound on the female one hour prior to the abortion. Simultaneously, females receiving an abortion must listen to detail description of the ultrasound before an abortion can be received. In April 2010, HB2780 was vetoed by the governor, but was quickly overridden by a vote in the Oklahoma legislature. This bill is now law. However, in early May 2010, Oklahoma courts granted a reproductive rights advocacy group, The Center for Reproductive Rights, a temporary injunction, preventing the state from carrying out the law. HB3075 requires facilities performing abortions, other than those performed for the safety of the mother, to post a legal notice in the waiting or consultation room. The legal notice must state that it is illegal to perform an abortion against the females will or to force a female to get an abortion. This bill was approved by the governor in April 2010. HB3284 creates the Statistical Abortion Reporting Act, requiring the OSDH to make an individual abortion form available to the Complications of Induced Abortion Report for the OSDH web site. Women seeking abortions would be required to provide information that would then be posted to the website. Information about marital status; age; race; education; number of live births; miscarriages; abortions; type of abortion; and reasons for abortion would be included in the report. Governor Henry vetoed HB3284 which was then overridden by the House of Representatives on a vote of 81-14 and by a Senate vote of 36-12. The measure was filed with Secretary of State in April 2010.

Emergency Preparedness: SB1295 modifies the membership for the Oklahoma Emergency Response Systems Development Advisory Council (ERSDAC) to include a person with a specialization in pediatric services. HB1888, approved by the governor in June 2010, becomes the Ambulance Service Districts Act requiring local residents of all but the two largest Oklahoma counties submit an EMS plan to the legislature and governor by April 1, 2012. With this legislation, county representatives will work with the OSDH to develop plans that assure a coordinated, statewide system to provide emergency medical services. The ERSDAC at the OSDH has responsibility for initiating the planning process and must work with the County Emergency Service Advisory Board to formulate the plan. A Board of local residents will be created to oversee the plan to ensure local control. Licensed ambulance services are required to respond to patients regardless of ability to pay or geographic funding districts.

Information Technology and Services: HB1704 created the Oklahoma Information Services Act and the position of Chief Information Officer (CIO) for the state. This position is appointed by the governor and has authority over the Information Services Division of the Office of State Finance. The CIO serves as the secretary of information technology and telecommunications purchasing director for all state agencies. In March 2010, Alex Pettit became Oklahoma's first CIO as he was named to the position by Governor Brad Henry. Reports estimate that Oklahoma employs approximately 1,500 information technology (IT) staff and spends greater than $340 million per year on services, not including personnel costs. The legislation directing the appointment of the CIO mandates that there be a net savings within two years of Pettit's hiring.

Data Capacity: HB3171 mandates that death certificates be filed with the OSDH within three days of the death. Funeral directors must sign the death certificate and are responsible for filing the certificate. The bill requires that the State Registrar of Vital Statistics provide all funeral directors and licensed physicians a system to electronically capture information and to file the death certificate with the OSDH. HB3171 was approved by the Governor in May 2010.

Voluntary Out Benefit Offer (VOBO): HB2363, approved by the governor in April 2010, permits state agencies to offer a voluntary buyout to state workers. This bill allows for $5,000, coverage of 18 months for health insurance premiums and a longevity payment. An agency must keep a VOBO position vacant for 36 months and the state employee accepting the VOBO is prohibited from being re-employed by the agency for at least three years. The bill reduces the full time equivalent authorization of an agency for every buyout. It has been estimated that the VOBOs

authorized by HB2363 will save the state approximately $70 million.

Population Health Ranking
The United Health Foundation's (UHF) "America's Health Rankings 2009" has ranked the state of Oklahoma 49th among all U.S. states, a downward shift of two positions from the UHF rankings published for 2008. The UHF report cited a number of challenges that must be addressed if Oklahoma hopes to improve its national standing. In particular, the report noted, (1) high prevalence of smoking, (2) a high prevalence of obesity, (3) limited availability of primary care physicians, and (4) high rate of preventable hospitalizations. The report also identified areas of strength for the state; namely, the low prevalence of binge drinking and the higher funding per capita for public health. To address the state's slide and position in the national rankings, the Board of Health and OSDH's Commissioner of Health, along with many external partners, launched the Oklahoma Health Improvement Plan (OHIP) in early 2010. The OHIP sets out flagship goals (e.g., tobacco use prevention, obesity reduction, and children's health) that must be given priority by OSDH program areas. Infrastructure goals that reviewed Oklahoma's public health finance, workforce development, access to care, and the effectiveness of health systems were established within the OHIP. In addition, there was review of societal and policy integration that examined social determinants of health and health equity as well as a recognition that the OSDH should pursue and advocate for policies and legislative reforms that maximize opportunities to improve the quality of life of Oklahoma's citizens. Future actions under the OHIP will include the development of a scorecard and reports that measure progress towards goals and objectives, incorporate ongoing community feedback to inform activities and projects, monitor strategies to reduce infant mortality, strengthen Oklahoma' public health workforce, and provide recommendations on improvement of public health financing.

B. Agency Capacity

Oklahoma is one of seven states in the nation that the Maternal and Child Health Services Title V Block Grant Program is administered by two separate state agencies. Under the provisions of Public Law 97-35, Section 509(b), the Oklahoma State Department of Health (OSDH) and the Oklahoma State Department of Human Services (OKDHS) share the administration of the Oklahoma Title V Block Grant Program. Administration of Part A (preventive and primary care services for pregnant women, mothers and infants) and Part B (preventive and primary services for children) is provided by the OSDH through the Community and Family Health Services, MCH. Part C (services for children with special health care needs) is administered by the OKDHS through the Family Support Services Division (FSSD), Health Related and Medical Services (HRMS). As the state health agency, the OSDH receives the federal Title V Block Grant funds from the Health Resources and Services Administration, Maternal and Child Health Bureau. Funding for the CSHCN Program is transferred to the OKDHS upon receipt of federal funds. Since the Omnibus Budget Reconciliation Act (OBRA) of 1981, the OKDHS has received its designated portion of the Title V monies to operate the CSHCN Program. The statutory authority which designates the OKDHS to operate the CSHCN Program is covered in Title 10 of the Oklahoma Statutes 1981, Section 175.1 et. seq. and article XXV of the Oklahoma Constitution.

The OSDH and the OKDHS collaborate to administer the CSHCN Program through a memorandum of agreement. This memorandum of agreement outlines the relationship between the two state agencies to include responsibilities for the Maternal and Child Health Services Title V Block Grant annual report and application. The current memorandum of agreement ends September 30, 2012. Copies of the memorandum of agreement may be obtained by contacting MCH at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

The Oklahoma Family Network (OFN) assures family input is received in the planning, development, and evaluation of Oklahoma Title V policy, procedures, and services. The OFN utilizes a statewide network of families to engage families as partners in Title V work at the individual, community, and policy levels. The Executive Director of OFN works closely with the

Title V MCH Director and Title V CSHCN Director attending monthly planning meetings, participating in quarterly calls of Region VI Title V Directors and Region VI Health and Human Services Administration (HRSA) partners as well as participating in multiple state level efforts as part of Oklahoma Title V.

The Oklahoma Title V Program enjoys strong relationships with state and community-based public and private partners. Title V is a strong, consistent voice in these relationships assuring a focus on the goal of promoting and protecting the health of all Oklahoma mothers and children as changes in state and local policy and procedures are explored to ensure and improve the statewide system of services. For example, the Oklahoma Health Improvement Plan (OHIP) Child Health Committee is focused on developing a state plan for improving children's health. The Title V MCH Director and Executive Director of OFN are members of this committee. Another example is the statewide infant mortality reduction initiative, "Preparing for a Lifetime, It's Everyone's Responsibility." MCH provides leadership for this initiative with critical support provided by state and community-based partners to impact preconception and interconception care and education; maternal infections; prematurity; postpartum depression; breastfeeding; tobacco use; infant safe sleep; and, infant injury prevention. Other examples include the Perinatal Advisory Task Force and Child Health Task Force. The Title V MCH Director co-chairs these task forces with the Director of Child Health from the Oklahoma Health Care Authority, the state's Medicaid agency. The Title V CSHCN Director is a member of the Child Health Task Force and the OFN assures family representation at meetings of both groups. These task forces have been instrumental in providing input for changes in state Title V and Medicaid policy and procedures (e.g., prenatal diagnostic services, prenatal social work services, lactation support services, perinatal quality improvement activities, child health screening schedules).

MCH, CSHCN and OFN schedule monthly meetings to plan and coordinate activities. During these meetings, data are presented to include positive and negative trends, information is shared on state and community-based activities, and discussion occurs about strategies to enhance the effectiveness of Title V in improving the health of mothers and children. In addition, these meetings provide the opportunity to coordinate activities in preparing the Title V Block Grant for submission. MCH coordinates the compilation of all information for submission of the needs assessment, annual report and application with CSHCN and OFN providing information to be incorporated into each of the grant areas.

MCH has close working relationships with state level programs and county administration within the OSDH and has multiple opportunities each month to engage in activities with OSDH leadership to communicate about Title V. The Commissioner of Health facilitates a monthly Executive Team Meeting that all Deputy Commissioners, Service Chiefs, and Program Directors are invited to attend. This meeting provides an opportunity for agency updates, sharing of program activities, asking of questions, and informal networking. The Deputy Commissioner of the Community and Family Health Services (CFHS) has two meetings a month with all CFHS Chiefs. These meetings provide the opportunity for the Chief of MCH to interact with all Chiefs in CFHS and to discuss crosscutting activities. In addition, the Deputy Commissioner of CFHS facilitates a videoconference every other week with County Health Department Administrators that further allows the opportunity for sharing of information and discussion of state health issues. Additionally, MCH routinely works with other OSDH programs on MCH issues such as preconception care, family planning, maternal depression, tobacco use prevention, dental care, obesity, injury prevention, immunizations, newborn hearing and metabolic screening, adolescent pregnancy prevention, school health, family resource and support services, child care, and early childhood.

Services for the MCH population are accomplished through the county health department system (69 of 77 counties), professional service agreements (e.g., physician, nurse practitioner), vendor contracts (e.g., ultrasounds, supplies), contracts with other state governmental agencies, requests for proposals (RFPs), and invitations to bid (ITBs). Oklahoma City-County Health Department and Tulsa City-County Health Department, who are administratively separate from

the OSDH, are key providers of MCH services in the two large metropolitan areas through direct contracts. Other community-based providers provide MCH services through professional service agreements, vendor contracts, or the RFP process.

CSHCN oversees the provision of services to children receiving Supplemental Security Income (SSI) within the state by providing training and guidance to the over 70 social services specialists located in OKDHS county offices across the state. These social services specialists are responsible for writing and monitoring service plans for all children who receive SSI and other services through the OKDHS. All equipment and services available through Title V CSHCN must be pre-approved by the state office. Families of children who receive SSI, but do not receive Medicaid, are also contacted to assure they are informed of services available through CSHCN.

CSHCN initiates and monitors professional service contracts with clinics that provide care to neonates in the Tulsa and Oklahoma City metropolitan areas. CSHCN also contracts with physicians for provision of psychiatric services to children in OKDHS custody. In addition to the state's Family-to-Family Health Information and Education Center, CSHCN contracts with the state's referral and resource network for CSHCN, a respite care facility, and a program that provides integrated community-based services for CSHCN. CSHCN meets with these contractors at least quarterly to ensure goals are being met through these contracts. CSHCN also has a representative on numerous parent advocate groups for CSHCN throughout the state and attends their meetings at least every other month.

MCH and CSHCN seek to assure culturally appropriate services through a variety of activities. Input from families via OFN, individual and group interactions, client satisfaction surveys, and online surveys provide insight to needed changes. Data collected through statewide surveillance (e.g., Pregnancy Risk Assessment Monitoring System, The Oklahoma Toddler Survey, Youth Risk Behavior Survey), vital records and programs are analyzed by multiple variables such as race, ethnicity, language, age, income, and education with information used to inform policy and program development and service delivery. Focus groups with culturally diverse groups (e.g., racial, ethnic, faith-based, urban, rural, youth) are conducted to learn how better to provide culturally sensitive service environments. The OSDH specifically requires that each OSDH employee complete a minimum of 3 hours of training on cultural competency each year as part of each employee's annual Performance Management Process (PMP). Interpreter training is also offered for OSDH state office and county employees through the OSDH Office of Minority Health. MCH requires county health departments and contractors to have a written community participation plan for MCH services with input in the development of the plan to be received from diverse populations served. These plans are reviewed on MCH site visits to the county health departments and contractors and technical assistance is provided as requested or identified. CSHCN seeks to insure representation from multiple cultural and ethnic backgrounds when conducting focus groups or gathering input for program operations.

C. Organizational Structure

In Oklahoma, state health and human services are loosely organized under the Cabinet Secretary of Health and the Cabinet Secretary of Human Services who are appointed by the Governor. Terry White, Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), is the Cabinet Secretary of Health and Howard Hendrick, Director of the Oklahoma Department of Human Services (OKDHS), is the Cabinet Secretary of Human Services. Health and human services agencies in Oklahoma include the Oklahoma State Department of Health (OSDH), OKDHS, ODMHSAS, Department of Rehabilitation Services, Office of Juvenile Affairs, Oklahoma Health Care Authority (OHCA) and Oklahoma Commission on Children and Youth (OCCY). The Department of Corrections and the Oklahoma State Department of Education are under different cabinet secretaries. The OCCY is charged with planning and coordinating children's services in the state in addition to providing oversight for juvenile services. The agency heads of all the major agencies serving children are appointed to

serve on the OCCY.

As previously described in B. Agency Capacity, Oklahoma administers the MCH Title V Block Grant through two state agencies, the OSDH and the OKDHS. The OSDH, as the state health agency, is authorized to receive and disburse the MCH Title V Block Grant funds as provided in Title 63 of the Oklahoma Statutes, Public Health Code, Sections 1-105 through 1-108. These sections create the OSDH, charge the Commissioner of Health to serve under the Board of Health, and outline the Commissioner of Health's duties as "general supervision of the health of citizens of the state." Title 10 of the Oklahoma Statutes, Section 175.1 et.seq., grants the authority to administer the CSHCN Program to the OKDHS.

The MCH Title V Program is located in the OSDH within the Community and Family Health Services (CFHS). The CFHS is organizationally placed under the Commissioner of Health. Suzanna Dooley, Chief of MCH, is directly responsible to the Deputy Commissioner of the CFHS, Stephen Ronck, who is directly responsible to the Commissioner of Health, Dr. Terry Cline. Dr. Edd Rhoades is Medical Director for the CFHS. Organizational charts of the OSDH, the CFHS, and MCH are on file in MCH with electronic versions or hard copy available by contacting MCH at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

The Title V CSHCN Program is located in the OKDHS within the Health Related and Medical Services (HRMS). The HRMS is organizationally placed under the Family Support Services Division. Karen Hylton is the Director of the CSHCN Program and Program Manager for the HRMS. Karen Hylton is directly responsible to Jim Struby, Programs Administrator. Jim Struby is directly responsible to Mary Stalnaker, Family Support Services Division Director. Mary Stalnaker is directly responsible to Marq Youngblood, Chief Operating Officer Human Service Centers who is directly responsible to the Director of the OKDHS, Howard Hendrick. The Medical Director for the CSHCN Program is currently vacant. Organizational charts of the OKDHS, Family Support Services Division, HRMS, and CSHCN Program are on file in MCH with electronic versions or hard copy available by contacting MCH at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

D. Other MCH Capacity

Organizationally, MCH consists of Child and Adolescent Health Division, Perinatal and Reproductive Health Division, and MCH Assessment. MCH also has Service level staff to include the Public Health Social Work Coordinator and MCH Nutrition Consultant that work across all MCH programs. The Child and Adolescent Health Division staff are primarily nurses and health educators. Programs and services include clinical services, school health, adolescent health, early childhood, child care, bullying, suicide prevention, teen pregnancy prevention, and injury prevention. The Perinatal and Reproductive Health Division staff are nurses, nurse practitioners, and health educators. Programs and services include preconception and interconception care, clinical maternity and family planning services, and preventive health education services for females and males of reproductive age. MCH Assessment staff are epidemiologists, biostatisticians, and program analysts. These staff evaluate MCH programs and services. MCH Assessment staff are also responsible for carrying out statewide population-based surveillance to include the Pregnancy Risk Assessment Monitoring System (PRAMS), the Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), and the Oklahoma First Grade Health Survey (1GHS).

Suzanna Dooley is the Title V MCH Director/Chief of MCH. Jim Marks is the Director of the Child and Adolescent Health Division. Dr. Edd Rhoades is the Medical Director for the Child and Adolescent Health Division. Jill Nobles-Botkin is the Director of the Perinatal and Reproductive Health Division. Dr. Pamela Miles from the Department of Obstetrics and Gynecology, University of Oklahoma Health Sciences Center (OUHSC) serves as the Medical Director to the Perinatal and Reproductive Health Division through a contractual agreement. Paul Patrick is the Director of MCH Assessment and is also the State Systems Development Initiative (SSDI) Coordinator.

Within MCH Assessment, Robert Feyerharm serves as the Title V Data Contact and Alicia Lincoln assists with the development of the MCH Title V Block Grant Application. Julie Dillard is the Public Health Social Work Coordinator and Nancy Bacon is the MCH Nutrition Consultant. Brief biographies of these key MCH staff are attached. Longevity of these staff working in the field of MCH range from five years for the Title V Data Contact to 32 years for the Child and Adolescent Health Division Medical Director. The MCH Title V Director has over 20 years in the field of MCH and has been the MCH Title V Director for eight years.

The MCH state office organizational chart currently shows 36 full time equivalent (FTE) positions of which 33 are currently funded for 2010. Of these, 20.62 FTE are funded by Title V Block Grant funds with the remaining 12.38 FTE funded by state and other federal grant funds. MCH is not anticipating reductions in state office staff during the next fiscal year though the current numbers do demonstrate a decrease in FTE with a loss of 5 funded FTE from the beginning of the previous five-year period, 2006-2010. With infant mortality an identified priority of the Oklahoma State Department of Health (OSDH), MCH is currently receiving support to fill vacancies. To assist with current state budgetary constraints, the Chief of MCH did make the decision in recent months to combine the responsibilities of the SSDI Coordinator with the Director of MCH Assessment.

The Chief of MCH has a routine planning meeting scheduled on Tuesday morning of each week with MCH Directors, the Public Health Social Work Coordinator, the MCH Nutrition Consultant and other MCH staff as identified depending on the area(s) being addressed. The meeting agendas include activities related to setting of priorities and initiating plans of action. These meetings also provide a routine time for MCH to meet with other areas in the agency such as HIV/STD, Public Health Laboratory, Office of Primary Care, and Turning Point as specific issues need to be addressed. On every other Monday morning, MCH has a routine staff meeting scheduled for all staff involved in MCH comprehensive program reviews. These meetings allow for development and revision of program review policy, procedure and tools as well as coordination of program review schedules. MCH also has a general staff meeting quarterly that brings all MCH staff together for agency updates, training, and Service-wide planning. This year trainings on the MCH Leadership Competencies have been incorporated into these quarterly meetings to facilitate development of leadership skills in all MCH state office staff. In addition, information needing to be shared between these various meetings is accomplished through Division staff meetings scheduled twice a month or through MCH Service-wide e-mail communications.

As indicated in B. Agency Capacity, MCH and CSHCN work closely with the Oklahoma Family Network (OFN), Oklahoma's Family Voices and Family-to-Family Health Information Center grantee, to assure family involvement. The OFN assures that families with interest in particular issues are connected with programs and have the opportunity to participate as partners in policy, program, and services development and evaluation. The Executive Director of the OFN, Joni Bruce, has been accepted to participate in the MCH Public Health Leadership Institute for the next two years. It is anticipated that this opportunity will provide new ideas to strengthen family involvement with both MCH and CSHCN. Joni Bruce is also designated by MCH and CSHCN to be the fifth Oklahoma delegate to the Association of Maternal and Child Health Programs (AMCHP). For the past three years, MCH and CSHCN have partnered with the OFN to provide Joining Forces: Supporting Family Professional Partnerships Conference. During this year's conference held on April 9, MCH and CSHCN partnered with families during breakout sessions to develop strategic plans regarding family input and leadership.

Karen Hylton, Program Manager for Health Related and Medical Services (HRMS), is the Title V CSHCN Director. Other state office staff includes John Johnson, Programs Field Representative, Family Support Services Division and Mike Chapman, Supplemental Security Income-Disabled Children Program (SSI-DCP). The Medical Director of CSHCN is currently vacant. Brief biographies of these key CSHCN staff are attached.

The system used by the Oklahoma Department of Human Services (OKDHS) to track the number

of FTE in the CSHCN Program is different than that used by the OSDH. No FTE within the OKDHS is totally funded by Title V. The OKDHS has over 70 FTE who work in county offices throughout the state and are responsible for ordering equipment and diapers provided through the Supplemental Security Income-Disabled Children's Program (SSI-DCP) as well as ensuring any other needs that can be met through the CSHCN Program are provided.

CSHCN has parent involvement which includes financial support for parent positions in various CSHCN programs (Oklahoma Areawide Services Information System (OASIS) parent coordinator - 1, OASIS staff - 5, Oklahoma Infant Transition Project - 1 and Tulsa Neonate Follow-up Clinic - 1). In addition, CSHCN also supports parent advocates through contracts with the University of Oklahoma Health Sciences Center (OUHSC) Autism Clinic, the Sooner SUCCESS Project at the OUHSC Child Study Center and the OFN.

State office CSHCN staff meet at least weekly to discuss training needs, plan site visits, and discuss CSHCN issues. CSHCN state office staff meet with field staff (either individually or collectively) at least monthly to provide training and discuss activities surrounding the provision of services to children receiving SSI.

The OASIS is the statewide toll free information and referral line for MCH and CSHCN (see Form 9). The telephone number for the Hotline is 1-800-OASIS. The OASIS is in operation Monday - Friday from 8:00 AM to 6:00 PM with an answering machine for after-hours calls. Individuals who leave a message after hours are contacted the following workday. TDD/TTY services for the deaf are available and bilingual staff are available to those who speak Spanish. The OASIS also maintains a website (http://oasis.ouhsc.edu/) for information and referral services. Oklahoma 211 works closely with the OASIS as 211 relies on the OASIS as their primary information and referral resource for MCH populations, to include CSHCN.

An attachment is included in this section.

E. State Agency Coordination

The Oklahoma State Department of Health (OSDH) and the Oklahoma State Department of Human Services (OKDHS) coordinate closely with other state health and human services agencies. The Commissioner of Health and Directors of the OKDHS, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and Oklahoma Health Care Authority (OHCA) actively engage in state planning activities together to improve the health status of Oklahomans. With Oklahoma's poor rankings on many health status indicators, these agency leaders set the tone and expectation for staff from health and social service agencies to partner in their work communicating that it is through our partnerships that addressing the needs of Oklahomans can best be met.

The Oklahoma Health Improvement Plan (OHIP) is one example of these coordinated efforts (www.ok.gov/health). The OHIP is a comprehensive plan to improve the health of all Oklahomans. The OHIP focuses on several key priorities and outcomes to include improving health outcomes through targeted flagships of children's health, tobacco use prevention, and obesity reduction; increasing public health infrastructure effectiveness and accountability; initiating social determinants of health and health equity approaches to address foundational causes of health status; and, developing and initiating appropriate policies to maximize opportunities for Oklahomans to lead healthy lives. Representatives on the OHIP Team include the key state agency directors as well as legislative leaders, private sector, members of the public health community, professional associations, and academia.

Another example of coordination much like the OHIP is the statewide infant mortality reduction initiative, "Preparing for a Lifetime, It's Everyone's Responsibility" (http://iio.health.ok.gov). This Initiative is not only supported by state health and human services agencies, but has also engaged a multitude of partners at the state, regional, and community levels. The Initiative has

eight specific focus areas to impact infant mortality: preconception/interconception care and education; prematurity; maternal infections; postpartum depression; tobacco; breastfeeding; infant safe sleep; and infant injury prevention. In addition to workgroups for each of the specific focus areas, there is also a media workgroup and a data workgroup. Membership of the workgroups is representative of state, regional, and local partners. MCH provides leadership for this initiative.

The Perinatal Advisory Task Force (PATF), initiated in May 2005, is an effort that has resulted in multiple positive changes to state health policy and health care provider services (e.g., increased benefits for pregnant females, statewide toll-free lactation support services for breastfeeding mothers and health care providers, quality improvement initiatives). The membership of this group includes the state health and human services agencies as well as health care providers, professional medical and nursing organizations, Oklahoma Primary Care Association, Healthy Start projects, academia, advocates, and family representatives. Through routine meetings, issues of concern around perinatal care are openly discussed and proposed strategies to intervene are identified and explored. Changes may be made in state agency policy, but there may be modifications to health care provider services that PATF members of professional medical and nursing organizations can assume the responsibility for facilitating, or needed changes in curriculum for medical, dental, and/or nursing students that PATF members in academia can take the responsibility for addressing. The PATF meets every odd numbered month on the third Tuesday from 5 p.m. to 7 p.m. The Chief of MCH co-chairs this task force.

With the success of the Perinatal Advisory Task Force, the OHCA Director of Child Health and the Chief of MCH, initiated a Child Health Advisory Task Force in February 2007. The task force meets the third Tuesday of every even numbered month from 5 p.m. to 7 p.m. Members of the Child Health Advisory Task Force include the state health and human services agencies, Oklahoma State Department of Education (OSDE), health care providers, professional medical and nursing organizations, Primary Care Association, Head Start, Smart Start Oklahoma, advocates, and family representatives. This group provided input into the development and structuring of the recently implemented Medicaid medical home model.

A memorandum of agreement between the OSDE and the OSDH provides for a collaborative relationship in facilitating the development and implementation of a comprehensive school health program in Oklahoma. Examples of activities include development of state level standards and protocols, provision of consultation and technical assistance to local school districts and school nurses, and collection of data.

Another close relationship is with the University of Oklahoma (OU), particularly the University of Oklahoma Health Sciences Center (OUHSC) campus. The OSDH, as the state's public health agency, actively participates in activities of the OUHSC and vice versa. The OSDH provides opportunities for students to complete clinical rotations, internships and preceptorships. Joint educational activities such as classroom instruction, grand rounds, conferences, and clinical trainings are accomplished in collaboration with the Department of Obstetrics and Gynecology, Department of Pediatrics, College of Public Health, School of Nursing, Child Study Center and College of Dentistry. The OU Department of Pediatrics and OU Physicians are key partners in supporting SAFE KIDS Oklahoma, a state level coalition focused on prevention of childhood injuries. The OU College of Public Health works with the OSDH to facilitate accomplishment of Public Health Certificates and/or Master and Doctorate of Public Health Degrees for OSDH staff both at the state and local levels.

In addition to OU, the OSDH and the OKDHS link with colleges and universities across the state to provide students seeking health and human services related degrees with hands-on learning experience. For each experience, a formal written agreement with goals and objectives for the experience and evaluation of the student's progress are outlined between the faculty, agency staff, and student. Students complete assignments by working side-by-side with county and/or state office staff.

The Oklahoma Leadership Education in Neurodevelopmental Disabilities (LEND) Program at the OUHSC Child Study Center receives support from both state agencies. The OSDH and the OKDHS along with other health and human services state agencies participate in planning meetings and provision of practicum experiences.

Early childhood is a priority area of the state for which both agencies are providing leadership through collaborative partnerships. Through support of the Oklahoma Partnership for School Readiness (OPSR), which is also the Early Childhood Advisory Council for Oklahoma, the early childhood plan is being implemented. The outcomes for the state plan are: a statewide comprehensive and coordinated system of early childhood services that meets the needs of families with young children; families nurture, teach and provide for their young children; children will be born healthy and remain healthy; and families with young children are able to find and afford high-quality care and education programs.

Joint activities are accomplished with state medical and nursing associations. These include initiatives to impact the health status of Oklahomans; planning for and evaluation of health services; publishing of data and corresponding recommendations for health systems improvement; and training and education.

The Oklahoma Hospital Association provides critical linkage and credibility to activities needing to be accomplished with hospitals across the state. This relationship has assisted with implementation of important services such as statewide newborn hearing screening; evaluation and restructuring of the emergency medical system; and, state preparedness in the event of a natural or planned disaster. In the coming year, the Oklahoma Hospital Association is a key partner in initiation of the Maternal-Infant Quality Care Collaborative. This Collaborative will bring birthing hospitals together to improve the quality of maternal and infant care.

The OSDH and the OKDHS work closely with Federally Qualified Health Centers (FQHCs) and tribal health care facilities to assure access to health care services. County health departments and local OKDHS offices work with these providers to link clients with needed services not available through the OSDH and the OKDHS. These partners are central to assuring access to primary care services, particularly for the uninsured and underinsured populations.

F. Health Systems Capacity Indicators

Introduction

See Forms 17, 18 and 19.

Data that address the Health Systems Capacity Indicators (HSCI) were drawn from multiple sources. Included in the list of sources are the Center for Health Statistics at the Oklahoma State Department of Health (OSDH), Oklahoma Health Care Authority (OHCA), Oklahoma Department of Human Services (OKDHS), Pregnancy Risk Assessment Monitoring System (PRAMS), and select national data sets.

In June 2009, a new Commissioner of Health took over the leadership of the OSDH. Much effort has been exerted to deal with budget gaps and shortfalls, and there has been a renewed focus on data. The Commissioner has elected to continue the performance management process and the developed data system that enables program areas to track performance targets. Each program area must identify goals, objectives and activities that are consistent with agency priorities and flagship issues. It is expected that data access should be routine and barriers to data sharing be removed.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	34.2	33.7	37.2	23.7	23.7
Numerator	857	858	971	632	632
Denominator	250522	254718	260901	266547	266547
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Sources: 2009 hospital discharge and population data are not yet available. Hence 2008 discharge data from Health Care Information, OSDH are used for numerator, U.S. Census Bureau 2008 population estimate for denominator.

Notes - 2008
Sources: 2008 hospital discharge data from Health Care Information, OSDH are used for numerator, U.S. Census Bureau 2008 population estimate for denominator.

Notes - 2007
Sources: 2007 hospital discharge data from Health Care Information, OSDH are used for numerator, U.S. Census Bureau 2007 population estimate for denominator.

Narrative:
Data used to monitor the rate of hospitalization for childhood asthma are obtained from Health Care Information (HCI), Center for Health Statistics at OSDH. These data are drawn from the hospital inpatient discharge dataset. A formal request must be submitted to the Program Coordinator of the Hospital Discharge Program. MCH analysts do not have routine access to raw electronic data; rather, data are provided in summary form to be included in the MCH Title V Block Grant. The Health Care Information Advisory Committee, guided by Oklahoma Statutes, determines access to hospital discharge data. In the past, HCI Advisory Committee members have shown great concern for the confidentiality of data, often restricting access for broader uses due to apprehension about exposing the hospital discharge data system to criticism for inappropriate use of data. However, more recent activity has seen a loosening of these concerns, particularly to health programs within OSDH. Both non-confidential aggregate and raw data have been requested by and released to internal agency departments. This is a promising data sharing practice, forecasting much wider uses of hospital discharge data. Through the use of data users agreements and formal requests, HCI leadership supports more extensive use of the data collected by that division.

Currently, the HCI Division within the Center for Health Statistics at OSDH has developed and is carrying out plans to create an agency-wide data warehouse as an effort to promote data sharing across agency program areas as well as monitor clients through a continuum of care. Data from nearly all sectors of the agency have been targeted for inclusion in the data warehouse. While the HCI data warehouse is in a stage of infancy, the activities surrounding its development portend greater data accessibility.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	85.8	88.4	87.9	88.7	91.5
Numerator	30192	31690	33539	33161	34711
Denominator	35197	35862	38156	37389	37931
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: OHCA CMS-416 EPSDT report, Federal Fiscal Year 2009.

Notes - 2008
Source: OHCA CMS-416 EPSDT report, Federal Fiscal Year 2008.

Notes - 2007
Source: Oklahoma Health Care Authority.

Narrative:
MCH analysts communicate directly with their OHCA peers to gain data on this measure.

In 2007, MCH acquired new staff that began the process of linking Medicaid data with vital records. This provided more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OSDH and the OHCA, assuring a collaborative process for analyzing the linked data.

By 2009, the Data Matching Analyst hired by MCH successfully linked 2005-2007 Oklahoma birth records with prenatal care and delivery Medicaid claims records. In addition, the Data Matching Analyst linked Medicaid claims of infants <1 year of age with maternal birth records.

In that same year, an interagency workgroup (OHCA and OSDH) was formed and facilitated by the Senior Biostatistician in MCH. The workgroup reviews the linked data, proposes areas for further analyses of the data, shares implications for policy and program services, and reviews and approves outside requests for use of the linked data. The workgroup has facilitated improved communication among analytic and policy staff of both agencies.

Linkage of Medicaid data and work of the interagency workgroups has been delayed this year with the Data Matching Analyst position being vacated in January 2010. Approval to rehire the Data Matching Analyst position has been obtained with the job posting released in May 2010. It is expected a candidate will be selected and placed in the position by August 2010. Once that position has been refilled, MCH will resume meetings of the interagency workgroup.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	69.5	72.3	70.9	72.1	77.6
Numerator	1637	1826	1728	1543	1704
Denominator	2355	2527	2436	2139	2197
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: OHCA data warehouse extract 4/6/2010, Federal Fiscal Year 2009.

Notes - 2008
Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Notes - 2007
Source: Oklahoma Health Care Authority.

Narrative:
Requests for SCHIP data are made directly to OHCA staff with copies of the request sent to the OSDH Chief of the Office of Federal Funds Development (FFD), as the primary liaison to OHCA, the state's Medicaid authority.

In 2007, MCH acquired new staff that began the process of linking Medicaid data with vital records. This provided more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data.

Linkage of Medicaid data has been delayed this year with the Data Matching Analyst position being vacated in January 2010. Approval to rehire the Data Matching Analyst position has been obtained with the job posting released in May 2010. Response to the announcement has been positive. It is expected a candidate will be selected and placed in the position by August 2010.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	71.5	66.4	67.6	69.2	69.2
Numerator	37019	36067	36161	37062	37062
Denominator	51775	54306	53469	53570	53570
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: Health Care Information, OSDH. 2009 birth data not yet available, hence provisional 2008 data used as an estimate.

Notes - 2008
Source: Health Care Information, OSDH. 2008 birth data still provisional.

Notes - 2007
Source: Health Care Information, OSDH.

Narrative:
Data for HSCI #04 are obtained directly from the raw birth certificate files. MCH has established a working relationship with the OSDH Center for Health Statistics that permits access to raw vital statistics data. This access allows MCH to gain a richer understanding of the birth data. Specific to this measure, MCH analysts can explore issues surrounding prenatal care in depth, rather, than relying on summary measures produced by analysts external to MCH.

The State Systems Development Initiative (SSDI) Project has had success in linking vital statistics data with Medicaid claims and eligibility data. Birth records for years 2005-2007 have been linked to corresponding years of Medicaid records. Match rates have been favorable (90%-95%) to valid analyses. MCH has utilized the linked records to compare the maternal health, demographic characteristics and pregnancy outcomes of women who delivered on Medicaid with women who were covered by private insurance. The FY2011 SSDI grant application will propose to continue these ongoing OSDH-OHCA linkages but also expand to include linkages between vital statistics data and WIC program data.

Access to prenatal care has been a focus of the "Preparing for a Lifetime, It's Everyone's Responsibility" Initiative, a statewide infant mortality prevention effort. Work is underway to identify ways the state can improve access to preconception and prenatal care, build awareness of the need for pregnant females to receive early and comprehensive pregnancy-related care, and improve systems of health care for all females of reproductive age.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	84.3	85.7	86.8	86.1	87.3
Numerator	403023	421001	439252	448225	474123
Denominator	478007	491517	506252	520410	542797
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: OHCA data warehouse extract 4/6/2010, Federal Fiscal Year 2009.

Notes - 2008
Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Notes - 2007
Source: Oklahoma Health Care Authority.

Narrative:
Requests for data are made directly to Oklahoma Health Care Authority (OHCA) staff with copies of the request sent to the OSDH Chief of the Office of Federal Funds Development (FFD), as the primary liaison to OHCA, the state's Medicaid authority.

Once the Data Matching Analyst vacancy has been filled, plans for that position, along with the MCH biostatisticians, are to explore this measure with direction from the interagency data workgroup. The interagency data workgroup has been dormant during the time MCH has experienced staff turnover. This data workgroup will become active again in August 2010.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	47.3	51.0	53.6	54.3	57.6
Numerator	45222	51019	55408	57581	64074
Denominator	95686	100011	103319	106022	111144
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: OHCA CMS-416 EPSDT report, Federal Fiscal Year 2009.

Notes - 2008
Source: OHCA data warehouse extract 5/19/2009, Federal Fiscal Year 2008.

Notes - 2007
Source: Oklahoma Health Care Authority, the State's Medicaid agency.

Narrative:
Requests for EPSDT data are made directly to OHCA staff with copies of the request sent to the OSDH Chief of the Office of Federal Funds Development (FFD), as the primary liaison to OHCA, the state's Medicaid authority.

Elsewhere, this section has described MCH staffing and its impact on the ability to gain access to and analyze data. That characterization holds true for HSCI#07B as well. MCH Assessment staff plan to resume linkages and analysis of matched Medicaid-vital records-PRAMS data. This should provide a channel to more fully analyze dental services provided by Medicaid. Future

plans are for the Data Matching Analyst and MCH biostatisticians to explore this measure with direction from the interagency data workgroup. This is also a priority area for the OHCA/OSDH Child Health Advisory Task Force.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	69.0	68.2	69.1	69.9	71.0
Numerator	7772	8251	8843	9711	10464
Denominator	11258	12102	12805	13883	14735
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: Oklahoma Department of Human Services, CSHCN Program.

Per CSHCN Program - Denominator data for 2009 are an estimate based on the known number of SSI recipients under 18 years of age from Dec. 2009 report.

Notes - 2008
Source: Oklahoma Department of Human Services, CSHCN Program.

Per CSHCN Program - Denominator data for 2008 are an estimate based on the known number of SSI recipients under 18 years of age.

Notes - 2007
Source: Oklahoma Department of Human Services, CSHCN Program.

Per CSHCN Program - Denominator data for 2007 are an estimate based on the known number of SSI recipients under 18 years of age.

Narrative:
Data for monitoring the HSCI#08 come from the CSHCN Program. The MCH Title V State Data Contact makes a request to CSCHN staff for these data. Direct access to raw data does not exist. Aggregate data are provided for inclusion in the MCH Title V Block Grant Annual Report and Title V Information System (TVIS). MCH and CSHCN meet monthly to discuss Title V program and data issues. While first-hand data access would improve understanding of the properties and quality of the CSHCN data, having program staff available through routine meetings and by telephone and email enable MCH analysts to obtain the information as needed. This mechanism for exchange of data is not likely to change.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2008	other	8.7	5.8	7.5

Notes - 2011
Source: 2008 Pregnancy Risk Assessment Monitoring System.

95% CIs:
Medicaid: (8.0%, 9.4%)
Non-Medicaid: (5.1%, 6.6%)
Total: (7.3%, 7.7%)

Narrative:
Monitoring data for this measure were extracted from Pregnancy Risk Assessment Monitoring System (PRAMS) population-based surveillance. The PRAMS surveillance system is a joint project of the Centers for Disease Control and Prevention (CDC) and MCH. In Oklahoma, the MCH Assessment staff carries out PRAMS surveillance. As a result, PRAMS survey data can be accessed on a routine basis. However, there are often considerable delays in obtaining timely data sets for weighted analyses. This is due to the manner in which weighted data sets are generated for State use. After a surveillance year is closed out, MCH Assessment forwards data to the CDC for data cleansing and weighting. Return of the weighted analysis data set is based on the scheduling of all PRAMS states as they submit surveillance data for weighting. Delays due to cleaning and weighting are common; however, the timeliness of the return of weighted data back to states has improved in the last few years. Oklahoma surveillance data for the year ending December 2009 is projected to be available for analysis in December 2010.

In 2007, MCH acquired new staff that began the process of linking Medicaid data with vital records. This provided more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OSDH and the OHCA, assuring a collaborative process for analyzing the linked data. Prenatal care was a priority for analyses of the linked Medicaid-vital records-PRAMS data.

During state fiscal year 2009, the Data Matching Analyst hired by MCH successfully linked 2005-2007 Oklahoma birth records with prenatal care and delivery Medicaid claims records. In addition, the Data Matching Analyst has linked Medicaid claims of infants <1 year of age with maternal birth records.

Linkage of Medicaid data has been delayed this year with the Data Matching Analyst position being vacated in January 2010. Approval to rehire the Data Matching Analyst position has been obtained with the job posting released in May 2010. Response to the announcement has been positive. It is expected a candidate will be selected and placed in the position by August 2010.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid,*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

non-Medicaid, and all MCH populations in the State					
Infant deaths per 1,000 live births	2007	matching data files	9.3	5.4	7.7

Notes - 2011
Source: 2007 linked Medicaid/birth-death records. Infant mortality rate calculated for 2007 birth cohort. Rates are provisional since 2007 and 2008 death records are not yet finalized. Infant mortality rate calculated from linked birth-death records will be slightly lower than period death rate (1,000 x no. infant deaths in 2007/no. live births in 2007) due to exclusion of unlinked infant death records because of missing BC #s.

Narrative:
Historically, infant death data by Medicaid participation were unavailable. This is because the Oklahoma death certificate did not contain information about Medicaid status. To tabulate infant death rates by Medicaid participation, an electronic link had to be established between the death certificate file and Medicaid program data. For many years, this link was not created. With the Oklahoma State Systems Development Initiative (SSDI) Project, the state developed plans to link these systems of data in order to enhance data capacity and to create data necessary to determine health disparities by Medicaid status.

As stated elsewhere, the MCH data matching analysis has enabled the linking of Medicaid data with vital records for select years. This has yielded more timely access and more comprehensive evaluation of Medicaid information. Once this position is refilled, the OSDH-OHCA collaborative process for analyzing linked data will resume.

Infant mortality is a priority set by the Oklahoma Health Improvement Plan (OHIP), the Commissioner of Health and MCH and is a key component of the analyses of linked Medicaid-vital records-PRAMS data. The Data Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality initiative is working to expand current MCH data capacity by effectively utilizing existing databases to assess the impact of the initiative on outcome measures. Representatives from MCH Assessment, OSDH Community Development Service, WIC, Vital Records, and city-county health departments currently sit on the Data Workgroup. During the past year, the Data Workgroup has produced health indicator profiles for the 77 counties in Oklahoma and linked the profiles with an interactive county map on the "Preparing for a Lifetime, It's Everyone's Responsibility" website. County health departments now have easy access to county health data. The Data Workgroup is planning to increase the range of demographic variables available for table construction with the infant mortality data in OK2SHARE, OSDH's online data query system. In addition, the workgroup is developing a statistical model which will allow OSDH to set more rigorous annual performance objectives for outcome measures such as infant mortality, low birth weight, and preterm birth rates based on the projected effectiveness of current initiatives such as "Preparing for a Lifetime, It's Everyone's Responsibility".

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the					

State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	other	73.5	88.3	79.4

Notes - 2011
Source: 2008 Pregnancy Risk Assessment Monitoring System.

95% CIs:
Medicaid: (68.9%, 77.6%)
Non-Medicaid: (83.9%, 91.6%)
Total: (76.1%, 82.3%)

Narrative:
Tracking data for this health indicator come from the PRAMS surveillance project. The PRAMS is a joint project of the CDC and MCH. As a result, PRAMS data are readily available to MCH analysts. However, there can be delays in receiving weighted analysis data sets. After a surveillance year is closed out, MCH Assessment forwards data to the CDC for data cleansing and weighting. Return of the weighted analysis data set is based on the scheduling of all PRAMS states as they submit surveillance data for weighting. Delays due to cleaning and weighting are common; however the timeliness of the return of weighted data back to states has improved in the last few years. Oklahoma surveillance data for the year ending December 2009 are projected to be available for analysis in December 2010.

Access to prenatal care is a focus of "Preparing for a Lifetime, It's Everyone's Responsibility", the statewide infant mortality initiative. Work is underway to identify ways the state can improve access to preconception and prenatal care, build awareness for early and comprehensive pregnancy-related care, and improve systems of health care for all Oklahoma women. The Oklahoma PRAMS project will include a preconception focused insert into its ongoing survey, beginning with June 2010 births. This development is a response to a performance measure identified in the Oklahoma Health Improvement Plan (OHIP). This measure monitors the proportion of women who receive quality preconception care as determined by American College of Obstetrics and Gynecology (ACOG) guidelines. Data should become available sometime in 2012. It is anticipated that by increasing the percentage of women receiving quality preconception care the percentage of women receiving first trimester prenatal care will also improve.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is	2008	other	67	76.9	70.9

greater than or equal to 80% [Kotelchuck Index])					

Notes - 2011
Source: Pregnancy Risk Assessment Monitoring System 2008.

95% CIs:
Medicaid: (62.1%, 71.5%)
Non-Medicaid: (71.6%, 81.5%)
Total: (67.3%, 74.3%)

Narrative:
The Oklahoma PRAMS surveillance project provides data for tracking this health indicator. The PRAMS is a collaborative project of the CDC and MCH. MCH analysts can easily access PRAMS data. Delays in receiving a weighted analysis data set for the most recent data collection year do occur. Once a surveillance year is closed, data are sent to the CDC for cleaning and weighting. Return of a final analysis data set is determined by the scheduling of all PRAMS states as they submit surveillance data for weighting. Delays due to cleaning and weighting are common; however the timeliness of the return of weighted data back to states has improved in the last few years. Oklahoma surveillance data for the year ending December 2009 is projected to be available for analysis in December 2010.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	185

Notes - 2011
Source: Oklahoma Health Care Authority.

Notes - 2011
Source: Oklahoma Health Care Authority.

Narrative:
Poverty level criteria for Medicaid and State Children's Health Insurance Program (SCHIP) eligibility are obtained from the Oklahoma Health Care Authority (OHCA), the State's Medicaid agency. It is a straightforward reporting of the various eligibility requirements for certain MCH populations.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2009	 185 185 185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2009	 185 185 185

Notes - 2011
Source: Oklahoma Health Care Authority.

Notes - 2011
Source: Oklahoma Health Care Authority.

Narrative:
Poverty level criteria for Medicaid and State Children's Health Insurance Program (SCHIP) eligibility are obtained from the Oklahoma Health Care Authority (OHCA), the State's Medicaid agency. It is a straightforward reporting of the various eligibility requirements for certain MCH populations.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	185

Notes - 2011
Source: Oklahoma Health Care Authority.

Notes - 2011
Source: Oklahoma Health Care Authority.

Narrative:
Poverty level criteria for Medicaid and State Children's Health Insurance Program (SCHIP) eligibility are obtained from the Oklahoma Health Care Authority (OHCA), the State's Medicaid agency. It is a straightforward reporting of the various eligibility requirements for certain MCH populations.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR	**Does your MCH program have**	**Does your MCH program**

SURVEYS	the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
MCH, via work performed under the State Systems Development Initiative (SSDI) Project, has access to linked birth/infant death records. MCH will maintain access to this linkage as routine. Despite some progress on data availability, standard linkages to external data such as Medicaid and WIC continue to be elusive.

In late 2009, MCH Assessment experienced staffing turnover that has stalled continued, ongoing linkages of data systems. As of June 2010, the Data Matching Analyst position remains vacant; it is projected that a new hire will be made in August 2010. While vacant for some months, the responsibilities of the SSDI Project Manager were combined in March 2010 with those of the new Director of MCH Assessment. These positions, along with the Senior MCH Biostatistician, will work closely to increase data capacity for Oklahoma MCH Programs.

MCH has had no real access to hospital discharge data. Formal requests for specific data elements must be made to Health Care Information (HCI), OSDH, to gain access to these data. Typically, hospital discharge data releases made to MCH are in aggregated form. While this is informative and useful for many types of analyses, it prevents MCH from linking surveillance data, vital statistics data, client services, and data from Medicaid files. New initiatives within HCI are leading to wider availability of that Division's data. A data warehouse and master person index are under development. These plans should increase accessibility of hospital discharge data.

Moreover, HCI has released non-confidential raw data on specific data elements to partners within the OSDH. This practice permits more expansive use of discharge data. For linked data, HCI employs a Data Warehouse Manager that oversees and performs linkages of datasets. Through this position, HCI has been willing to partner with in-house departments to carry out ad hoc linkages for data studies. Because HCI intends to create an agency-wide data warehouse, these ad hoc linkages should be viewed as short term solutions to data needs. However, they do present important opportunities for MCH to increase data capacity over the near term. MCH Assessment is developing an analysis proposal for submission to HCI to examine linked hospital discharge data for characteristics of infants born prior to 37 weeks gestation (preterm births).

For FY2011, MCH plans to resume its evolving relationship with OHCA to expand and enhance linkages between MCH surveillance data, such as PRAMS, birth and death records, and Medicaid program records. Informal conversations with WIC staff have revealed a mutual interest in linking WIC data to birth and death records as well as PRAMS survey data. Finally, MCH will redouble its efforts to gain access to the Oklahoma Birth Defects Registry (OBDR).

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
MCH has responsibility for conducting and analyzing the Youth Risk Behavior Survey (YRBS), the source of the data used to address this health indicator. The prevailing concern with HSCI#09B is ensuring that YRBS response rates maintain a level that yields a sufficient sample size for survey estimation. An intensive effort is put forth to persuade high schools to participate in the statewide YRBS. Experience indicates that school participation in YRBS will be an ongoing challenge. Schools have a high volume of extracurricular activities that moderate their willingness to participate in surveys like the YRBS. The Oklahoma statewide survey is conducted every other year in accordance with the Centers for Disease Control and Prevention (CDC) YRBS surveillance schedule.

The most recent data available for the Oklahoma statewide YRBS is year 2009. These data have been weighted and were used in the completion of the MCH Title V Five Year Needs Assessment for 2011-2015. These data have been made available to the OSDH OK2SHARE web query system. This online, publicly available data system, maintained by Health Care Information (HCI) at OSDH, ensures that YRBS data are available to all parties with an interest in adolescent health-related topics. MCH has completed fact sheets, covering each of the YRBS focus areas, including use of alcohol and tobacco products, to be published in July 2010. Once these materials have cleared the review process, they will be distributed to the high schools and MCH partners.

In May 2010, MCH began discussions on selecting a sample for the 2011 school year. This cycle of the statewide YRBS will be administered in the spring of 2011.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Performance measures are used to monitor the effect that Title V services have on important health outcomes and processes. These measures in effect are markers of progress in improving health and reducing related risks of our target populations. While many external forces beyond the control of the Title V programs can affect these measures, they still provide direction for Title V services and assure that the focus remains on health improvement. Figure 3 (from the Maternal and Child Health Services Title V Block Grant Program Guidance), Title V Block Grant Performance Measurement System, presents a schematic approach that begins with the needs assessment and identification of priorities and culminates in performance measures leading to improved outcomes for the Title V population.

Every five years, a comprehensive needs assessment is accomplished with state priorities identified. Based on these priorities, state performance measures are developed and resources allocated to impact the priorities. During interim years, needs assessment activities continue to monitor changes and identify gaps that may impact priorities and performance measures. In addition, MCH and CSHCN evaluate the resources assigned to address each priority. Based on the continuing needs assessment process and the annual evaluation of resources and their impact, state priorities may be redefined, performance measures changed, and resources realigned resulting in changes in specific program activities within the four levels of the MCH "pyramid" (direct health care, enabling, population-based, and infrastructure building services).

MCH uses the national and state performance measures in the agency performance and budget report submitted each fall to the state Legislature by the Oklahoma State Department of Health (OSDH). These measures are also part of the OSDH strategic plan for improving the health of Oklahomans.

The national outcome measures and national and state performance measures are also shared by MCH and CSHCN with internal and external partners so they are aware of Title V priorities and the focus of resources. This assists with planning of collaborative activities and more effective use of limited resources in addressing common priorities.

An attachment is included in this section.

B. State Priorities

The priorities chosen were selected by MCH and CSHCN to move Oklahoma toward the improved health status of all Title V population groups. Data to highlight areas of need were analyzed from the following sources: population-based surveillance data from the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Oklahoma Youth Risk Behavior Survey (YRBS), the Oklahoma First Grade Health Survey (1GHS); Oklahoma vital records; U.S. Census population estimates; the State and Local Area Integrated Telephone Survey (SLAITS); needs assessments of other Oklahoma MCH programs; private, non-profit health-based surveys or studies; agency program data from the OSDH, the Oklahoma Health Care Authority (Medicaid data) and Oklahoma Department of Human Services (OKDHS); and, other federal and state surveys.

The process of priority selection for this current Title V Needs Assessment was approached differently from previous Title V Needs Assessments for Oklahoma and included the utilization of newly available electronic resources, such as online surveys and video conferencing during task force meetings. MCH and CSHCN found a way to better capture what was otherwise considered an inaccessible population. Staff took advantage of available electronic resources through the internet, more specifically, SurveyMonkey, in an attempt to gather more input from all sectors of the state's diverse populations. The survey included both open ended questions about the health

needs of the three Title V population groups (A, B, and C) and questions on ranking the importance of selected health conditions. These health conditions were identified during the MCH and CSHCN, Perinatal Advisory Task Force (PATF), and Child Health Advisory Task Force (CHATF) meetings, including discussions with stakeholders and families, prior to developing the online survey. The results from over 700 completed online surveys were received and evaluation and analysis of the input guided MCH and CSHCN to create a smaller subset of priorities for each of the Title V population groups. Part A priorities were then presented to the PATF, and Part B and Part C priorities were presented to the CHATF. These "expert" groups then determined, via a process of organized committee meetings, review of data, and thoughtful discussion, recommendations for Oklahoma Title V priorities for MCH and CSHCN to consider in order to gain the best possible outcomes for the Title V population groups.

MCH, CSHCN, and the Oklahoma Family Network (OFN) explored input from the data collected for the needs assessment, current priorities for the Oklahoma Health Improvement Plan (OHIP), OSDH Strategic Targeted Action Teams (STAT), ongoing work by the OFN, Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs), and CSHCN program at OKDHS. The priorities discussed at task force meetings were modified, collapsed, and analyzed to determine what priorities were feasible, could be acted upon at all service levels of the pyramid, and would enact change in the health of Oklahomans. The following were then selected for more in-depth discussion: Part A: Access to Care, Unintended Pregnancy, Infant Safe Sleep; Part B: Access to Care, Depression, Obesity, Tobacco Use; and Part C: Child Care, Transition, Access to Care. It was then decided by MCH, CSHCN, and OFN to combine Access to Care into one overarching priority for all three population groups; Tobacco Use Prevention, Obesity and Preconception Health were also added as overarching priorities for all three population groups. Part A priorities were then selected; unintended pregnancy and infant safe sleep were chosen based on their prevalence and ability to impact infant mortality rates. Part B priorities originally selected were depression and suicide among youth and motor vehicle injuries. Part C priorities were child care and transition to adulthood.

Upon further discussion a decision was made to remove depression and suicide and add infant mortality instead, due to the high profile campaign in the state to combat the issue and the statewide initiative to reduce infant mortality "Preparing for a Lifetime, It's Everyone's Responsibility." Although many of the priorities address some aspect of infant mortality and the overarching goal of Title V is to reduce infant mortality, MCH, CSHCN and OFN felt it important to be consistent with OSDH, the Oklahoma Health Improvement Plan (OHIP), and state goals and objectives leading to infant mortality being placed on the priority list. The decision was made to consider depression and suicide under the access to care priority.

The priorities were modified slightly, based upon a careful review of the resources available and the relationship of Title V to other services that will partner with the MCH,CSHCN, and OFN efforts: (Note that infant mortality is ranked highest, the others are listed in order of overall impact to all MCH population groups and then by MCH population groups.)

1) Reduce infant mortality;
2) Improve access to comprehensive health services for the MCH population;
3) Reduce the prevalence of tobacco use among the MCH population;
4) Reduce the prevalence of obesity among the MCH population;
5) Improve preconception health for females and males of reproductive age;
6) Reduce unwanted, unplanned pregnancies;
7) Improve infant safe sleep practices;
8) Reduce motor vehicle injuries among children and youth;
9) Improve transition services for CSHCN;
10) Improve the system of child care for families of CSHCN.

Next, MCH, CSHCN, and OFN analyzed existing national performance measures and current state performance measures to determine their usefulness in addressing the new priorities. It was

noted that national performance measures addressed several of the state priorities. State performance measures no longer pertinent to the priorities were discontinued, and new measures were created to assist the state in monitoring its progress toward impacting the priorities. Five previous state performance measures were retained with two new state performance measures* and two revised** state performance measures developed for 2011:

1) The percentage of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.
2) The percentage of adolescents grades 9-12 smoking tobacco products.
3) The number of families with a child with special health care needs receiving respite care provided through the CSHCN program.
4) The percentage of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution.
5) *The percentage of children with special health care needs who receive child care services at licensed child care facilities and homes.
6) *The percentage of women receiving quality [American College of Obstetrics and Gynecology (ACOG) standards] preconception care.
7) **The percentage of infants who are put to sleep on their backs.
8) The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.
9) **The percentage of Medicaid eligible children with special health care needs who report receiving dental services other than for routine dental care.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	54	50	67	58	61
Denominator	54	50	67	58	61
Data Source				Screening and Special Services, OSDH	Screening and Special Services, OSDH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health.

Notes - 2008
Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health.

Notes - 2007
Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health.

a. Last Year's Accomplishments
All newborns born in Oklahoma were screened through the Newborn Screening Program (NSP) for the disorders of phenylketonuria (PKU) and other amino acid disorders; congenital hypothyroidism; galactosemia; sickle cell disease; hemoglobinopathies; cystic fibrosis (CF); congenital adrenal hyperplasia (CAH); medium chain acyl-CoA dehydrogenase deficiency (MCAD) and other fatty acid disorders; and organic acid disorders. The number of disorders identified in calendar year (CY) 2009 included: PKU (2) and hyperphe (2); congenital hypothyroidism (18); classic galactosemia (3); sickle cell disease (5); hemoglobin disease, including sickle cell disease, sickle beta thalassemia, sickle beta zero thalassemia, CC disease (10); CF (14); CAH (3); fatty acid disorders - MCAD (9); short-chain acyl-coenzyme A (CoA) dehydrogenase (SCAD) (3); amino acid disorders (3); organic acid disorders (5); hemoglobin C trait (111); and sickle cell trait (431). One hundred percent of newborns received short-term follow-up (STFU) services for diagnosis and 100% of affected newborns were referred to long-term follow-up (LTFU) for care coordination services. All cases of confirmed diagnosis for newborn screening disorders received genetic counseling.

For CY 2009, all newborns (542) with sickle cell trait and hemoglobin C trait were referred for counseling and 53 families received counseling from a board certified genetic counselor. All newborns identified with an out-of-range CF screen were referred for genetic counseling (102 of the 110 received counseling).

Activities of the Sickle Cell Association continued to be impacted due to elimination of state line item funding in 2008. Lack of funding hindered advocacy activities such as school individual education plan (IEP) assistance and transition planning for individuals who were identified with sickle cell disease and sickle cell trait, as well as advocacy and support for families.

Expansion to adopt the uniform panel recommended by the American College of Medical Genetics (ACMG) was completed for the amino acid disorders, fatty acid disorders, and the organic acid disorders. Oklahoma screening included 53 of the 54 core disorders.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened all newborns born in Oklahoma for mandated conditions			X	
2. Provided short-term follow-up for all newborns identified to diagnosis		X		
3. Referred all affected newborn to long-term follow-up		X		
4. Provided genetic counseling to all families with newborns having confirmed diagnosis	X			
5. Completed expansion of newborn screening for the amino acid disorders, fatty acid disorders and organic acid disorders	X			

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Follow-up staff has been acquired for the NSP. In addition, staff continues to develop follow-up protocols and conduct lab validation studies. The only disorder on the ACMG panel that is pending is biotinidase. It is anticipated that biotinidase will be added to the current panel by early 2011. Additional equipment has been purchased for screening of biotinidase deficiency; however, testing has not been implemented with the need to address laboratory space constraints and lack of personnel to run the testing.

Long-term follow-up care coordination services are being provided to children and youth with special health care needs and include an Adult Transition Program for adolescents with sickle cell disease and a PKU Formula/Food Program.

An evaluation of the state genetics plan continues in collaboration with the Evaluation Committee of the Oklahoma Genetics Advisory Council (OGAC).

c. Plan for the Coming Year

All newborns born in Oklahoma will continue to be screened through the NSP for the disorders of PKU, congenital hypothyroidism, galactosemia, sickle cell disease, hemoglobinopathies, CF, CAH and MCAD. Recently, the Advisory Committee for Heritable Disorders for Newborns and Children recommended the addition of SCID (Severe Combined Immune Deficiency) to the panel. An additional activity the NSP will undertake is investigating testing methodology and funding in anticipation of adding this test to the current Oklahoma panel.

The NSP will maintain comprehensive STFU services to assure all infants with out-of-range screen results are followed until resolution (e.g., diagnosed as normal, affected or lost to follow-up). Affected newborns will be followed until documentation of treatment date (if applicable), referral to pediatric sub-specialist, genetic counseling date, and enrollment into available LTFU services. In collaboration with the University of Oklahoma Health Sciences Center (OUHSC) and the Center for Genetics -- Warren Clinic, Tulsa, the NSP will continue to provide LTFU services to all affected newborns except for those diagnosed with CF. Infants diagnosed with CF will continue to be referred to the CF Center in Tulsa or Oklahoma City (follow-up for CF ceases once the NSP confirms that the infant has been seen by a pediatric pulmonologist). Currently, three fulltime LTFU care coordinators (Metabolic, Endocrine, and Sickle Cell Disease) and one metabolic dietitian are supported through contracts with the OUHSC. STFU and LTFU services are provided in collaboration with the medical home. Genetic counseling for CF and hemoglobinopathies is provided in Oklahoma City and Tulsa through contractual agreements.

The NSP will continue to provide education and low-phenylalanine formula to adults and low-protein food to children with PKU.

Implemented activities of the OGAC state genetics plan will continue including educational outreach. The Metabolic Workgroup will continue to meet to facilitate implementation of expansion of the ACMG uniform panel. The OGAC will continue to meet three times a year and its nine committees will meet as needed. The Newborn Screening and Pediatrics Committee of OGAC will continue to address newborn screening follow-up.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**52588**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	52588	100.0	9	2	2	100.0
Congenital Hypothyroidism (Classical)	52588	100.0	36	18	18	100.0
Galactosemia (Classical)	52588	100.0	7	3	0	0.0
Sickle Cell Disease	52588	100.0	19	15	15	100.0
Organic Acid Disorder	52588	100.0	24	5	5	100.0
Sickle Cell Anemia (SS-Disease)	52588	100.0	431	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	52588	100.0	104	3	3	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	52588	100.0	26	9	9	100.0
Other fatty acid disorder	52588	100.0	25	3	3	100.0
Other amino acid disorder	52588	100.0	58	3	3	100.0
Hemaglobin C trait	52588	100.0	111	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	54.9	56	57.4	58.8	60

Annual Indicator	50.4	50.4	56.9	56.9	56.9
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60.9	61.5	62.7	63.9	65.1

Notes - 2009
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

a. Last Year's Accomplishments
The 2005-2006 National Survey of Children with Special Health Care Needs showed 56.9% of families, with a member who was a child under 18 with special health care needs, were partners in decision making at all levels and were satisfied with the services they received. This is an increase from the 2001 survey, which found 50.4% of families were satisfied.

CSHCN contracted with the Sooner SUCCESS Project at the University of Oklahoma Child Study Center (OU CSC). Sooner SUCCESS provided care coordination for children, youth, and their families across the state. Sooner SUCCESS also provided support to local communities through convening and facilitating coalitions made up of families, local service providers, and other stakeholders. These coalitions worked together to develop community resources. In each of the nine counties where Sooner SUCCESS operated (Blaine, Canadian, Major, Garfield, Logan, Kingfisher, Creek, Rogers, and Tulsa) there was both a county coordinator and a county coalition. The coordinators and coalitions not only helped families access services but assisted communities in organizing and developing services when unmet needs were identified. There were regional and state teams that further worked to coordinate services around the state. Evaluators for Sooner SUCCESS completed an annual survey, Community Needs Assessment, which helped them identify unmet needs.

In the Blaine County Sooner SUCCESS Coalition, a blog was developed to list activities and helpful information for and about CSHCN, their families, and service providers. The Canadian County Physicians Alliance was developed to allow physicians to network and learn about resources and other providers in the mental health field. In Garfield County, training events were held on subjects such as Insure Oklahoma (a health care coverage program administered by the

Oklahoma Health Care Authority, the state Medicaid agency, that covers eligible employed families) and early intervention for hearing loss in very young children.

CSHCN maintained contracts with several organizations that have paid family members on their staffs: Oklahoma Areawide Services and Information System (OASIS), Oklahoma Infant Transition Program (OITP), Tulsa Neonatal Follow-up Clinic, and the Autism and Sickle Cell clinics at the University of Oklahoma Health Sciences Center (OUHSC).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported SoonerSUCCESS through provision of funding and technical assistance for their regional care coordination activities				X
2. Maintained contracts with statewide 1-800 referral and resource system, neonatal follow-up projects and specialty medical clinics to support funding of family members as staff				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OITP helps families with infants in the OU Children's Medical Center's neonatal intensive care unit (NICU) understand treatments and diagnoses and coordinate between doctors, specialists, equipment providers, and the family to ensure that the family understands what they will need to do when their infant leaves the hospital. The OITP social workers help families find funding sources to pay for care, treatment, and equipment. Staff continue to help families navigate the myriad of medical appointments infants with special needs may have after being released.

The OU CSC in Oklahoma City performs assessments for autism. A staff family partner, funded through a CSHCN contract with Sooner SUCCESS, acts as a liaison between OU CSC staff and families. This creates better communication and leads to better diagnosis and treatment.

The Oklahoma Family Network (OFN) hosted the 3rd annual Joining Forces Conference on April 9. The conference brings together families and professionals to create partnerships and improve programs. Over 100 attendees participated in one of more than a dozen workshops that were co-led by a family member and a representative from a state agency. CSHCN's workshop focused on developing methods to allow families from around the state to give input into CSHCN activities without having to drive to Oklahoma City. The plan is to develop an online method of gathering input through regional "ambassadors" who will represent local communities.

c. Plan for the Coming Year

CSHCN will continue to contract with the OASIS, OITP, Tulsa Neonatal Follow-up Clinic, and OUHSC to support funding of family members as staff.

Through the efforts of Sooner SUCCESS to acquire additional funding, the OU CSC's parent partner position will be fulltime. The OU CSC provides assessment and treatment for many developmental disabilities. The fulltime position for the family partner will mean more time to help families before, during, and after a child's assessment. This position's primary responsibility will be to maintain communication between the families, the community, and the OU CSC while providing information on resources to assist and support families. Understanding the professional's perspective enables the family partner to advocate and share the needs of families by translating personal experiences and perspectives into general system recommendations. In addition, Sooner SUCCESS will expand to Delaware and Cleveland counties.

To help families become stronger advocates for their children, the OFN plans to partner with two hospitals in Oklahoma to provide trained OFN staff to visit and provide information and emotional support to families with children admitted to the neonatal and pediatric intensive care, pediatric, and oncology units of the hospitals.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.8	59.3	60.5	60.5	50.2
Annual Indicator	53.3	53.3	49.7	49.7	49.7
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50.7	51.2	51.7	52.2	52.7

Notes - 2009
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

a. Last Year's Accomplishments

The 2005-2006 National Survey of Children with Special Health Care Needs found that 49.7% of children 18 or younger receive coordinated, ongoing, comprehensive care within a medical home in Oklahoma. This has declined since 2001 when 53.3% of families received care in a medical home.

MCH and CSHCN served as resources for the Partnership for a Healthy Canadian County (PHCC) as work continued on this pilot project for a Health Access Network (HAN). Working with the University of Oklahoma Child Study Center (OU CSC) and Sooner SUCCESS, PHCC developed a plan that put physicians in a "hub" with "spokes running out" to specialists, new technologies (such as electronic medical records), and educational opportunities. The model is expected to help families receive coordinated care that meets all their needs and not be complicated to use.

The Fostering Hope Clinic, a multi-agency collaboration that provided a medical home for children in Oklahoma Department of Human Services' (OKDHS) custody, completed its fourth year. The clinic operated two days each week. Medical professionals who staffed the clinic maintained the child's medical history and provided tests and treatments as needed.

Collaboration with OU CSC, the Utah Collaborative Medical Home Project, and the Oklahoma Joint Oklahoma Integrated Network (JOIN)/211 continued as Oklahoma medical home portal pages were developed. The Utah Med Home Portal (located at http://www.medhomeportal.org) was developed to give primary care providers as well as families the tools they need to give the best care and treatment to children with chronic conditions. It provided information on what a medical home is, useful information put together by families to help other families, listings of school and education resources and personnel, modules on conditions and their diagnoses, information about transition issues, and extensive lists of resources. Oklahoma's 211 system represented six areas across the state. Each area 211 focused on resources in its area. The entire 211 system in Oklahoma began updating the software for their databases. As the updates were completed, each 211 sent data to Utah to be accessed through the Oklahoma portal.

Oklahoma's Head Start Dental Home Initiative (HSDHI) was launched in March 2009. HSDHI worked through Head Starts and Early Head Starts to assist children and their families in learning good dental practices and overcoming difficulties in finding a dental home. HSDHI applied for and received a federal grant in September. One of the initiatives, funded in part by this grant, was to help develop sustainable networks of quality dental homes.

In April 2009, Oklahoma Senate Bill (SB) 135 was passed. This legislation established a state license for National Board Certified Behavioral Analysts and created a professional standard for Applied Behavioral Analysis (ABA). In addition, it provided for increased training for the evaluation and diagnosis of autism spectrum disorders and enhancement of SoonerStart, Oklahoma's 0-3 Early Intervention Program, by providing professional training for the treatment of children with autism spectrum disorders. SoonerStart was directed to replicate Early Foundations, an autism treatment and outreach model that offers behavioral intervention through trained providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided support to the Fostering Hope Clinic to provide services using the medical home model	X			
2. Collaborated with partners to improve Oklahoma's 211 system				X
3. Partnered in the launching of Oklahoma's Head Start Dental Home Initiative				X

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Sooner SUCCESS is on the Oklahoma Health Care Authority's (OHCA) Medical Advisory Task Force. The OHCA created and maintains the task force to develop a medical home model for SoonerCare (Medicaid) enrollees. Sooner SUCCESS collaborates with the OHCA on the medical home model through training sessions provided to family members, care coordinators, and primary care providers.

The OU CSC is finalizing plans to host what is hoped to be the first of several physician training sessions on the STAT (Screening Tool for Autism in Toddlers and Young Children). The STAT is an empirically based, interactive measure developed to screen for autism in children between 24 and 36 months of age. The tool is designed for use by community service providers who work with young children in assessment or intervention settings and who have experience with autism. The STAT consists of 12 items and takes about 20 minutes to administer.

c. Plan for the Coming Year

CSHCN, MCH, Sooner SUCCESS, and OU CSC will explore ways to continue the efforts initiated through the "Helping Family Practitioners Improve Developmental Screening Project" which is a Centers for Disease Control and Prevention (CDC) project funded October 2008 to October 2010 and administered by the AUCD (Association for University Centers on Disability). Researchers at the OU CSC have recruited 12 primary care practices (3 in Canadian County, 2 in Garfield County, 1 in Murray County, 1 in Logan County, 2 in Jackson County, 2 in Grady County, and 1 in Oklahoma County) to participate. The intervention has four components: 1) academic detailing (training) regarding the American Academy of Pediatrics' practice guidelines regarding developmental and autism screening plus training on how to use validated developmental screening tools; 2) pre-chart audit to assess developmental screening and referral performance in the practice with feedback to the practice; 3) practice facilitation given free of charge to the practice (a Practice Enhancement Assistant employed by the OU CSC makes weekly visits to the practice); and 4) nine-month post facilitation audits. The goal is to increase the rate and improve the quality of each practice's developmental and autism screening and referral capacity.

To help families become stronger advocates for their children, the Oklahoma Family Network (OFN) plans to partner with two hospitals in Oklahoma to provide trained OFN staff to visit and provide information and emotional support to families with children admitted to the neonatal and pediatric intensive care, pediatric, and oncology units of the hospitals.

The continuing partnership between Head Start (HS) and Early Head Start (EHS) and the American Academy of Pediatric Dentists (AAPD) has the goal of helping children find dental homes. The two-pronged HSDHI will organize networks of dental professionals who will agree to act as a dental home. MCH and CSHCN will continue to participate in these meetings. HS and EHS staff will continue training in how best to communicate to parents the importance of effective oral health practices and having a dental home for their children.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61	62.5	64.1	62.9	64.2
Annual Indicator	56.4	56.4	61.6	61.6	61.6
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65.5	66.8	68.1	69.4	70.7

Notes - 2009
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

a. Last Year's Accomplishments
The National Survey of Children with Special Health Care Needs data for 2005-2006 indicated that 61.6% of children 18 or younger with special health needs had adequate levels of insurance coverage to provide for required health services. This is an improvement from the 2001 survey when 56.4% of children with special health care needs had adequate levels of insurance coverage.

According to statistics from the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS), there was a 1.15% decrease in the number of children and youth with special health care needs receiving services through Medicaid. The reason for this change was the drop in the number of children in foster care. Children in foster care numbered 11,201 in 2008, this decreased to 9,483 in 2009. The OKDHS worked diligently to reduce the number of children placed into foster care through policy and programs changes leading to more children being placed for adoption.

Children continued to be approved for and receive services through the Tax Equity and Fiscal Responsibility Act (TEFRA) Program which provided Medicaid eligibility to children who were

ineligible for Supplemental Security Income (SSI) due to their parent's income but who met nursing home or hospital level care and were able to reside at home. Enrollment in the TEFRA Program grew to 308, up from 229 the previous year.

The OHCA completed the development of procedures to provide metabolic formulas to children who receive services through SoonerCare, Oklahoma's Medicaid Program. The procedures were to expedite payment to providers and be less cumbersome for families as the paperwork process was to be eliminated and formula changes to be approved more quickly. Previously, some of these formulas were provided through the CSHCN Program.

The Oklahoma Areawide Services and Information System (OASIS) maintained a database of resources for children and adults with special needs. Their toll free phone number (1-800-426-2747) was staffed to help people find resources to meet their needs. The OASIS processed 9,753 calls requesting assistance. Approximately 758 of these calls requested help with getting some sort of medical/psychological testing, other medical service or information about Medicaid/Medicare. Resource information was also accessible on the OASIS website (http://oasis.ouhsc.edu/) through an online directory. This directory received 35,156 visits.

The OASIS Family Outreach Coordinator arranged for "On the Road" conferences in Enid, Shawnee, and Durant. These conferences brought together representatives from the CSHCN Program, Developmental Disabilities Services Division, and the OHCA who met with parents and guardians to help them understand the process of getting help with their medical needs through the SSI-Disabled Children's Program; SoonerCare; Early Periodic, Screening, Diagnosis and Treatment Program (EPSDT); TEFRA; and waivered services.

All families receiving support and services through the Sooner SUCCESS Project received assistance with identifying the appropriate mechanism for paying for the services they needed.

CSHCN continued to be an active participant of the OHCA and Oklahoma State Department of Health (OSDH) Child Health Advisory Task Force to assist both agencies in developing improved benefits and services for Oklahoma's low income families who rely on publicly supported health care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Worked with the OHCA to finalize changes to Medicaid policy to cover metabolic formulas				X
2. Assured families were aware of resources and referral assistance provided by the OASIS, OKDHS, OHCA and Sooner SUCCESS		X		
3. Participated as part of Child Health Advisory Task Force				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN had been paying for formula for children with metabolic disorders who were eligible for Medicaid, but the OHCA now allows families to get these formulas pre-authorized for coverage

under SoonerCare. CSHCN is also facilitating the process of helping families work with their private insurance companies to obtain formula the private insurer will cover.

"On the Road" conferences, organized by the Family Perspective Committee of the OASIS, are being held to help families learn what services are available through programs such as SoonerCare, SoonerStart (Oklahoma's 0-3 Early Intervention Program) and Title V. The conferences are held at different times of the year in different cities and towns around the state to allow as many families as possible to attend at least one event. A CSHCN staff participates in these conferences and meets with parent and professional groups to explain the eligibility requirements and services provided through SoonerCare, TEFRA, and the SSI-Disabled Children's Program.

CSHCN continues to participate in the Child Health Advisory Task Force.

c. Plan for the Coming Year

The feasibility of having two "On the Road" conferences at the same time in the two metropolitan areas (Oklahoma City, Tulsa) in the fall and spring is being considered. Costs and agency personnel are just two of the hurdles that will need to be overcome for this to happen. It is anticipated that this would facilitate more individuals being able to attend and learn about programs that can help their families pay for needed services.

The Child Health Advisory Task Force will continue to advise the OHCA and Title V on identifying better policy, benefits, and services for children who rely on public support for health care and provide advocacy in making the recommendations of the task force a reality. The CSHCN Director will continue membership on the Child Health Advisory Task Force.
The OASIS will continue to host a database of resources for children and adults with special needs. The software for the database will be upgraded to IRis for the Web 4.0. This new software will improve the search capability of the site as well as allow for posting updates and important messages. The OASIS will continue to maintain a statewide toll-free 1-800 number for families to call.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	71.4	73.2	75.1	91	92
Annual Indicator	67.6	67.6	90.3	90.3	90.3
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	93	94	95	96	97

Notes - 2009
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

a. Last Year's Accomplishments
The 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) showed the services of 90.3% of children under the age of 18 with special health care needs were organized in ways that families could easily use them. Comparisons cannot be made to 2001 data due to a change in the questions from the previous version of the survey.

The Sooner SUCCESS Project served CSHCN and their families by helping them find and access needed services. In Creek County, the Families of Children with Special Health Care Needs Support Group began its third year. It received sponsorship for many of its activities, such as an annual resource fair, from the Oklahoma Family Alliance. The Tulsa Advocates for the Rights of Citizens with Developmental Disabilities (TARC) contacted the support group to work together. Sooner SUCCESS assisted in meeting the needs of 494 families across the state.

CSHCN continued to attend events around the state, such as the family focused "On the Road" conferences in Enid and Shawnee, the annual Metro disABILITY Resource Conference in Oklahoma City, and the annual Governor's Conference on Disabilities (held in Tulsa), to inform families of available services through Title V. CSHCN also held training sessions to educate the Oklahoma Department of Human Services (OKDHS) staff on Title V programs and how best to help families access them.

OKDHS staff assigned to the SSI-Disabled Children's Program (DCP) attended an event hosted by Supporters of Families with Sickle Cell. The event was designed to help families find resources available in the Tulsa area. Organizations had booths and tables set up in the hallway outside of the dining area so families could come and go as they pleased. Numerous questions were asked about SSI-DCP and about eligibility criteria for SoonerCare, Oklahoma's Medicaid Program.

The Oklahoma Family Network (OFN), a statewide organization created to act as a resource and encouragement for families, hosted the second annual "Joining Forces Conference" on April 25, 2009. More state and community-based agencies sent representatives than in the first year. Topics included how to set up a parent support group, telling one's story most effectively to speak for all families, building and maintaining good partnerships, and teaching agencies how the family point of view can help them become more effective. The keynote speaker, Nancy DiVenere of the Parent to Parent USA, presented models of professionals and families coming together to improve community services. Ms. DiVenere came in a few days early and met with representatives from various agencies and service organizations to talk one-on-one about developing partnerships.

SSI-DCP workers in local OKDHS offices routinely helped families find out what services were available in their communities or in neighboring communities. This assistance was especially beneficial in rural counties where there was no Sooner SUCCESS presence or community advocate to help families navigate the system.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreached to families with children with special health care needs to inform them of available state benefits and programs		X		
2. Partnered with the OFN to provide the "Joining Forces Conference" focused on professionals and families coming together to improve community services				X
3. Assisted families through local OKDHS offices to find available services in their communities or in neighboring communities		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Sooner SUCCESS provides support to local communities through convening and facilitating coalitions made up of families, local service providers, and other stakeholders to develop strategies leading to increased local capacity. County and regional coordinators continue to help families access services. Some needs are met through public and private agencies and organizations and others are met by organizing community services around the unique needs of the individual family. Sooner SUCCESS has been operating in nine counties, but received additional funding to expand into two more counties this year.

Sooner SUCCESS is presently conducting a Community Needs Assessment. This annual survey is used to determine where there are unmet needs. Coordinators will use this information to develop community resources to fill those needs.

CSHCN regularly participates in the "On the Road" conferences sponsored by the Family Perspective Committee of the Oklahoma Areawide Services Information System (OASIS). Professionals present program information to families around the state. Families can learn about programs and ask questions of the program experts. Professionals have the opportunity to dispel misconceptions or help families work through some of their frustrations with the agencies and organizations where they get services.

The OFN hosted the annual "Joining Forces Conference" on April 9, 2010. Eileen Forlenza, Family Advocate from Colorado, was the keynote speaker.

c. Plan for the Coming Year

A primary function of Sooner SUCCESS is to help families learn of needed resources. To this end, the coordinators for three counties (Garfield, Kingfisher, and Major) will continue their blogs.

Area 2, comprised of Creek, Major and Tulsa counties, is on Facebook. Use of these communication networks will allow coordinators to potentially inform large numbers of people about events, give out helpful advice, and help families to network.

With support from MCH and CSHCN, OFN will host the fourth annual "Joining Forces Conference". This event will bring together families and professionals to forge collaborative efforts to improve the lives of children and their families. OFN will also continue to participate on the Child Health Advisory Task Force, a joint collaboration between the Oklahoma State Department of Health (OSDH), the Oklahoma Health Care Authority (OHCA) and other partnering agencies. The task force's goal is to improve health systems for Oklahoma's children as well as develop and execute the medical home model. OFN has a Facebook page that provides a list of events and meetings occurring around the state for families of CSHCN.

OFN will continue to house the Family-to-Family Health Information Centers (F2F HIC) for Oklahoma. Funded through the Maternal and Child Health Bureau (MCHB) as well as community grants and other state agencies, the F2F HIC acts as a warehouse of information on a variety of subjects such as finding or maintaining durable medical equipment, how to deal with insurance companies and how best to deal with doctors and specialists. MCH and CSHCN will continue in their roles on the Steering Committee for the F2F HIC.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.2	6	6.2	45	46
Annual Indicator	5.8	5.8	43.7	43.7	43.7
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	47	48	49	50	51

Notes - 2009
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007

Source: National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

a. Last Year's Accomplishments

The 2005-2006 National Survey of Children with Special Health Care Needs reported that 43.7% of children under the age of 18 received the services necessary to make appropriate transitions to adult health care, work, and independence. Comparisons cannot be made to 2001 data due to a change in the questions from the previous version of the survey.

The MCH Title V Director and the Executive Director of the Oklahoma Family Network continued to serve on the Oklahoma State Department of Education (OSDE) Individual's With Disabilities Education Act, Part B Advisory Committee. The OSDE's FFY 2009 Annual Performance Report for the Individual's with Disabilities Education Act (IDEA), Part B found that 84.2% of children with an Individual Education Plan (IEP) graduated with a regular diploma. Of children who were 16 or older, 99.8% had transition activities written into their IEP's. To be counted, the IEP had to include coordinated and measurable goals and services designed to enable the student to meet reasonable post-secondary school goals. The OSDE continued to work with local school districts on improving methods of readying students to transition to post-secondary school life. The OSDE provided technical assistance to local school districts on subjects such as writing and implementing transition, self-advocacy and self-determination goals for IEP's, increasing involvement in extracurricular activities, and methods of increasing graduation rates (such as offering incentives to stay in school).

Returned surveys from 113 youth who graduated from high school found that 77.9% of them had either obtained some type of competitive employment or had entered a post-secondary school. The OSDE worked on determining methods to increase the survey response rate. A handbook, to be published in both Spanish and English, was created to send to the local school districts to assist them in developing and writing transition goals for IEP's.

The 2009 Oklahoma Transition Institute (OTI) was held September 9-11. This was the fourth annual OTI and approximately 400 people concerned about student transition gathered to learn about programs being developed and implemented around the state. The Director of the Oklahoma Department of Human Services (OKDHS) was the opening speaker at the 2009 Institute. Sessions available for attendees to participate in included: "Transition Activities That Make a Difference"; "Accessing Housing Services"; "Utilizing Systems of Care and Wrap Around Services to Help Students Meet Their Transitional Goals"; and, "The Why's and How's of Teaching Self-Determination and Self-Advocacy Skills".

The OTI is a project of the Oklahoma Transition Council (OTC). The Council was started in 2002 to assist transition education throughout Oklahoma. The Council has representatives from such agencies and organizations as the Oklahoma Departments of Education, Human Services and Rehabilitation Services; school districts throughout the state; Oklahoma Family Network; University of Oklahoma (OU) Child Study Center and Zarrow Center for Learning Enrichment; and, the Oklahoma Autism Network. Besides the annual OTI, the Council's website, hosted by the OU Zarrow Center, http://education.ou.edu/zarrow/, has materials to help with teaching transition, self-determination, and self-advocacy skills.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Served on the OSDE IDEA, Part B Advisory Committee				X
2. Participated on the multi-agency Oklahoma Transition Council which hosted its fourth annual Transition Institute for training community-based educators, service providers, parents, students and other providers				X
3.				
4.				
5.				
6.				
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b. Current Activities

CSHCN continues to be an active participant with the OTC. The OTC is an interdisciplinary, interagency group working toward improved transition practices across multiple agencies. The OTC provides professional development opportunities through annual institutes to increase transition education for educators, related service providers, parents, students, and other providers. Over the past four years, the OTI has provided educational opportunities and support to over 2,100 professionals and 35 teams throughout Oklahoma in collaboration with the National Secondary Transition Technical Assistance Center (NSTTAC).

c. Plan for the Coming Year

OTC and CSHCN will review the findings of the Oklahoma Pediatric Sickle Cell Program's telephone survey targeting patients who had been transitioned at least two years previously. The target population included adolescents, 13-21 years of age, who were seen at the Comprehensive Pediatric Sickle Cell Clinic at OU Children's Hospital in Oklahoma City. The program provides health literacy training, adult living skills assistance, referral to community-based programs, transition planning with identification of adult health care providers, and help with scheduling appointments. The goals of the survey included determining how well young adults with sickle cell were doing medically, socially, and in relation to employment; identifying and exploring any medical problems young adults had experienced after transition; and whether or not the person had stayed with the adult health care services arranged for her or him.

Both OSDE and OTC will use the data from the OSDE Oklahoma High School Exit Survey to determine changes to existing services or what new activities need to be developed to help youth with special needs in transitioning to adult life. The survey was sent to students in the 11th grade who had an IEP. A follow-up survey will be sent to the original respondents one year after they graduate to determine how they are progressing towards meeting post-high school goals. Many students indicated they were involved in the development of their IEP's: 39.4% set goals for themselves, 64.2% answered questions during their IEP meetings, and 1.1% led the meeting. Sixty-five percent of those who returned the survey had been involved in on-the-job training. The survey asked participants to indicate everyone who helped them in preparing for life outside of high school. The five most commonly provided answers were parent/guardian, special education teacher, regular education teacher, school counselor, and career/technical education teacher. Thirty-one percent of respondents believed they would have no problems after high school. Of those who believed there would be challenges, the five most indicated problems were having enough money to live, being able to go to college, parents, lack of transportation, and being able

to find a job.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83.6	74.2	76.4	80.8	82.1
Annual Indicator	75.7	80.4	80.1	73.6	73.6
Numerator	37087	40268	41564	38803	38803
Denominator	48992	50085	51890	52722	52722
Data Source				National Immunization Survey & U.S. Census Bureau	National Immunization Survey & U.S. Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	81	82	83	84

Notes - 2009
Source of data: CY2009 data are not yet available, hence CY2008 data are used as a placeholder. Numerator is estimate from National Immunization Survey, Q1/2008-Q4/2008, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series .

Denominator is 2008 population estimate of 2 year olds obtained from the U.S. Bureau of the Census.

95% CI: 73.6% ± 6.8%.

Annual performance objectives for 2010-2014 were revised to reflect decrease in 4:3:1:3:3 immunization coverage from 80.1% in 2007 to 73.6% in 2008. While not a statistically significant decrease, the drop may reflect a national decline in 4:3:1:3:3 immunization coverage of 2.0% (±1.5%) from 2007-2008. Despite this decrease, long term prospects for immunization coverage are positive. With the renewal of CHIP in Feb. 2009, passage of the Health Care Reform Bill, and the American Recovery and Reinvestment Act of 2009, stimulus money will be available to provide immunization coverage for low-income children. In addition, OSDH has launched

Operation Buzzer-Beater to ensure vaccinations of 24 month-olds who have not received sufficient immunization shots.

Notes - 2008
Source of data: Numerator is estimate from National Immunization Survey, Q1/2008-Q4/2008, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series .

Denominator is 2008 population estimate of 2 year olds obtained from the U.S. Bureau of the Census.

95% CI: 73.6% ± 6.8%.

Notes - 2007
Source of data: Numerator is estimate from National Immunization Survey, Q1/2007-Q4/2007, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series .

Population data in denominator were obtained from the U.S. Bureau of the Census.

Annual Performance Objectives for 2008-2012 have been revised to reflect expected increase in % of 19-35 month olds receiving vaccinations. OSDH will be launching Operation Buzzer-Beater to ensure vaccinations of 24 month-olds who have not received sufficient immunization shots.

a. Last Year's Accomplishments
National Immunization Survey (NIS) results for year 2008, the latest data available, showed a coverage rate of 73.6% for children 19-35 months of age who had received these immunizations. With these results, Oklahoma ranked 39th nationally. In 2008, Oklahoma ranked 25th with a coverage rate of 80.1%, according to NIS data for 2007.

The Oklahoma State Department of Health (OSDH) maintained its policy of providing immunizations to any child that presented at a county health department needing immunizations with priorities for outreach and direct services being the uninsured and underinsured populations. If immunizations were provided to an insured child, county staff worked with the parent/guardian to link the child with his/her primary health care provider for future immunizations. Additionally, county health departments were able to recoup year-round cost reimbursement for services provided to children eligible for Medicaid for the fourth consecutive year.

Immunizations continued to be tracked by both private and public health care providers using the Oklahoma State Immunization Information System (OSIIS). This system was supported with Medicaid funds received through a contractual agreement with the Oklahoma Health Care Authority (OHCA).

MCH continued collaboration with the OSDH Immunization Service on The OK by One Project. This project, modeled after a similar project in New Mexico, was implemented in 2004 as a strategy to improve vaccine protection levels and particularly that of the 4th DTaP, a common problem found in low immunization coverage. The OK By One Project offers a simplified immunization schedule, accepted by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), that allows completion of the primary vaccination series by the one-year-old well child visit.

Additional strategies to improve immunization rates included Immunization staff conducting immunization audits in 552 child care centers and providing immunization coverage assessments for over 60% of state practices enrolled in the Vaccines for Children (VFC) Program.

Immunization representatives continued to target clinics in both the public and private sectors to

be the recipients of CDC's AFIX intervention (Assessment, Feedback, Incentives and eXchange). AFIX is a proven method of practice level improvement that raises coverage rates and improves standards of care.

MCH continued to review the immunization status of children during site visits to county health departments and contractors and provide technical assistance as indicated as well as participate in the OSDH Immunization Advisory Committee meetings held during the year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided immunization to any child presenting at a county health department for immunizations	X			
2. Assisted families with insurance coverage to link with the child's primary health care provider for immunizations		X		
3. Maintained contract with the OHCA for reimbursement of immunizations and support of the electronic state immunization registry				X
4. Supported statewide efforts of the "OK by One" Project to facilitate improvement in vaccine protection levels				X
5. Monitored immunization services provided through site visits to service providers to assure children receiving immunizations on schedule				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Oklahoma continues to place a strong emphasis on targeting pockets in need of immunization services and to use population-based immunization data from all 77 counties in seeking improvement. Data from the state immunization registry have been used to develop intervention strategies including the OK by One immunization schedule, day care audits and our new intervention called Operation Buzzer Beater (OBB). OBB is a specific reminder intervention targeting 21 month-old children who are lacking one or two doses of completing the primary series. Approximately 13% of state children lack just one dose by 24 months of age to complete the series. Work has begun to link OSIIS and The Oklahoma Toddler Survey (TOTS) data to aid in these efforts.

OSDH Immunization Field Consultants (IFC) continue to complete immunization audits in child care centers. Staff are working with centers to raise vaccine protection levels with a follow-up visit to centers falling below the 90% coverage level. Immunization representatives continue to target clinics in both the public and private sectors to be the recipients of CDC's AFIX intervention.

Provider participation in the OSIIS registry increased during the year from 871 to 944. Additionally, over 1,000 schools and 208 child care centers utilize the registry for tracking state immunization requirements. Among the state's population of children <6 years of age, over 90% have multiple vaccinations recorded in the registry.

c. Plan for the Coming Year
MCH will continue its close partnership with Immunization Service and support activities targeted toward attaining the goal of 90% of children up-to-date with the primary series of immunizations by their second birthday. Activities will continue to focus on support and evaluation of the OK By One Project, improved vaccination of child care attendees, clinic-level quality improvement, and Operation Buzzer Beater. Efforts will continue to expand private sector partnerships with business and medical communities to promote the health of children.

MCH Assessment and the Immunization Service will continue to develop analysis plans to link Pregnancy Risk Assessment Monitoring System (PRAMS) and TOTS survey data with OSIIS data in order to improve vaccine coverage rates at 24 months of age. An annual report will be developed to help identify barriers, gauge progress and discover disparities in vaccinations.

Oklahoma is one of 14 states that received over $600,000 in American Recovery & Reinvestment Act (ARRA) funding to develop a public health billing system plan that allows reimbursement for immunization services provided to individuals covered through private insurance. Although specific to immunization reimbursement, the OSDH will develop broad functionality to cover services rendered for other OSDH programs. The OSDH will use resources generated through this project to offset existing costs and for future public health program expansion. The Chief of MCH is one of the members of the OSDH Private Insurance Billing Workgroup.

The OSDH will maintain its policy of providing immunizations to any child that presents at a county health department needing immunizations with priorities for outreach and direct services being the uninsured and underinsured populations. If immunizations are provided to an insured child, county staff will work with the parent/guardian to link the child with his/her primary health care provider for future immunizations.

A contractual agreement will remain in place between the OSDH and the OHCA allowing reimbursement for immunization services received through the county health department system for children covered by Medicaid. In addition, a contractual agreement will remain in place allowing reimbursement for Medicaid administrative costs related to the OSIIS.

MCH will continue to participate as an ex-officio member of the OSDH Immunization Advisory Committee.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27.3	31.4	27.1	26.8	30
Annual Indicator	27.4	30.4	30.4	31.0	31.0
Numerator	2020	2281	2292	2302	2302
Denominator	73677	75011	75486	74346	74346
Data Source				OSDH vital statistics & U.S. Census Bureau.	OSDH vital statistics & U.S. Census Bureau.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29.8	29.6	29.4	29.2	29

Notes - 2009
Source: Numerator: Health Care Information, Denominator: U.S. Census Bureau. 2009 data not yet available, hence provisional 2008 data used.

Annual performance objectives have been revised given current data.

Notes - 2008
Source: Numerator: Health Care Information, Denominator: U.S. Census Bureau. 2008 data not yet finalized.

Notes - 2007
Source: Numerator: Health Care Information, Denominator: U.S. Census Bureau.

a. Last Year's Accomplishments
Oklahoma's 2008 teen birth rate for adolescents aged 15-17 years climbed to 31.0 live births per 1,000 females from 30.4 in 2007, an increase of 2.0% (provisional data). For the most recent year final birth data were available, Oklahoma's 2007 birth rate of 30.4 for 15-17 year olds was 36.9% higher than the national rate of 22.2. Of the 7,616 infants born in 2007 to females 19 and younger, 2,386 infants or 31.3% were born to mothers 17 years of age or younger and 5,230 infants or 68.7% were born to mothers eighteen and nineteen years of age. In 2007, sixty-one of Oklahoma's 77 counties had teen birth rates higher than the 2005 national average of 21.4 per 1,000 females age 15 to 17.

MCH continued to place an emphasis on building infrastructure and supporting adolescent health services statewide. The MCH Adolescent Health Coordinator attended a two-day training sponsored by the Maternal and Child Health Bureau (MCHB) funded State Adolescent Health Resource Center at the University of Minnesota. This training provided information to the Adolescent Health Coordinator on how to build support for adolescent health internally within the Oklahoma State Department of Health (OSDH) and externally with partners.

The Adolescent Health Coordinator continued a train-the-trainer program, "Parents, Let's Talk", taken from the Advocates for Youth educational campaign. Those participating in the one-day training included youth servicing organizations, ministers, social workers, parents, academia, juvenile justice, and school personnel to include counselors, teachers, and coaches. The training emphasized healthy youth development, understanding adolescent brain maturation and what teens need, internet safety, asset building, human immunodeficiency virus and sexually transmitted diseases (HIV/STDs) information, and how to talk to youth about sexuality.

The Interagency Coordination Council (ICC) for Prevention of Adolescent Pregnancy and STDs, a legislatively appointed interagency group, continued to meet. Key activities centered around educating legislators and local school district administration as to Oklahoma's poor statistics on adolescent pregnancy and STDs and the need for additional resources to be provided in efforts to improve adolescent health. The Chief of MCH and the Adolescent Health Coordinator were appointed members to the ICC.

Five state-funded adolescent pregnancy prevention projects continued to be administered through MCH, two in county health departments and three in community-based private nonprofit

organizations. Activities of the projects focused on middle school populations. Five additional adolescent pregnancy prevention projects, implemented in late 2008 and early 2009 as a result of a onetime $500,000 line item appropriation from the state legislature to implement the "Postponing Sexual Involvement" (PSI) curriculum, were reduced to two. With state revenue shortfalls, state line item funding was also discontinued for the two adolescent parenting programs, one in Oklahoma County and the other in Tulsa County. The adolescent parenting programs were provided technical assistance from MCH in seeking reimbursement through Medicaid for their activities.

Youth Services of Tulsa continued a project of outreach and education to hard-to-reach/at-risk youth in Tulsa County using federal Title X family planning funds received through a contractual agreement with MCH. Youth identified as low-income, alternative lifestyle, uninsured and/or at-risk of poor health outcomes received preventive health education and were assisted in linking with additional social and health care services as needed.

Family planning clinical services continued to be provided to adolescents through county health departments and contract providers. These services included a comprehensive physical examination, preventive education on HIV and STD transmission, education on contraceptive methods (including abstinence), and encouragement of parental involvement.

With Oklahoma's African American population having more than twice the infant mortality rate of the white population and high rates of adolescent births, MCH received special funding from the Title X Family Planning Region VI Office to implement two special projects, one in Oklahoma County and one in Tulsa County. These projects focused on providing outreach, education, and family planning clinical services to the African American population.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Received technical assistance on development of a state adolescent health plan from the State Adolescent Health Resource Center				X
2. Provided a train-the-trainer program, Parents Let's Talk, focused on healthy youth development, adolescent brain maturation, safety, etc.				X
3. Participated in the activities of the ICC for Prevention of Adolescent Pregnancy and Sexually Transmitted Diseases to facilitate systems/policy changes				X
4. Provided funding and technical assistance to adolescent pregnancy prevention projects and a community-based hard-to-reach/at-risk youth project			X	
5. Provided clinical family planning services through county health departments and contract providers	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oklahoma City-County Health Department (OCCHD) and Tulsa Health Department (THD) are utilizing Title V funds to implement new initiatives focused on improving the health of neighborhoods. These efforts work within the community to assist the community to address

health and social needs to improve the community's health status. Zip code areas of high adolescent pregnancy, infant mortality, and chronic disease rates are being targeted.

MCH is currently applying for federal funds through the newly established Office of Adolescent Health. If received, these funds will be used to support the implementation and evaluation of adolescent pregnancy prevention projects throughout the state that will utilize evidenced-based curriculum in middle schools, high schools, and alternative schools.

MCH is also working with the Oklahoma State Department of Education (OSDE) and Oklahoma Department of Human Services (OKDHS) on the use of school-based social workers to provide adolescent pregnancy prevention classes in schools across the state. Discussions are also occurring with tribal contacts to utilize tribal staff assigned to schools to further expand these efforts.

c. Plan for the Coming Year

MCH will explore, with key stakeholders, strategies to lessen the impact of state budget cuts to services for adolescent pregnancy prevention. MCH will continue discussions with the OSDE, OKDHS, and tribal contacts in hopes of gaining support to use school-based staff in adolescent pregnancy prevention efforts. MCH will offer training, travel reimbursement, curriculum, technical assistance, and evaluation support. In addition, the Adolescent Health Coordinator, School Health Coordinator, and health educators within MCH will promote positive youth development through technical assistance and guidance to school health nurses working with middle school students across the state.

The Adolescent Health Coordinator will continue providing expertise on the different life stages of adolescence, brain development and maturation, and the link to risk-taking behaviors including depression, suicide ideology, attempts, and completion. Presentations are scheduled for school districts, youth ministers, The Oklahoma Children's Justice Center, Girl and Boy Scouts of America, Campfire USA, Latino Community Development Agency, Oklahoma Department of Human Services Partners Conference for Oklahoma Families, and others.

The Adolescent Health Coordinator will serve on the Governor's Task Force on Prevention of Underage Drinking assuring the issue of alcohol use and its relationship to adolescent pregnancy remains part of the discussions.

Guidance will be provided to the OCCHD and THD as specific steps are taken in identified zip code areas to improve the community's health. Adolescent pregnancy prevention efforts will be integrated into these steps.

County health departments and contract providers will continue to provide family planning services to adolescents which include a comprehensive physical examination, prevention education on sexually transmitted infections (STI) and HIV, and education on contraceptive methods (including abstinence). Support will continue to the OCCHD and THD to maintain the special family planning projects focused on the African American population.

A Request for Proposals will be developed, posted, and an award made for enabling and population-based services to adolescents who are low-income, alternative lifestyle, uninsured, and/or at-risk of poor health outcomes in Tulsa County.

The Chief of MCH and Adolescent Health Coordinator will continue involvement on the ICC for Prevention of Adolescent Pregnancy and STDs.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	41.2	37.7	38.7	39.6	40.2
Annual Indicator	36.8	34.4	35.1	39.7	39.7
Numerator					
Denominator					
Data Source				Oklahoma Oral Health Needs Assessment	Oklahoma Oral Health Needs Assessment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40.7	41.3	41.8	42.3	42.8

Notes - 2009
Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH. 2009 data not yet available, hence 2008 used as provisional estimate.

Notes - 2008
Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH.

Notes - 2007
Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH.

a. Last Year's Accomplishments
Data from the statewide dental health needs assessment of third grade children in 2008 revealed the percent of third grade children having protective sealants on at least one permanent molar tooth was 39.7%; the percent of third grade children having dental caries experience was 72.0%; and, the percent of third grade children having untreated dental decay was 32.7%. These data were the most current data available.

The Oklahoma Dental Loan Repayment Program became effective in November 2006 with permanent rules adopted by the Board of Health in March 2007. This program was designed to increase the number of dentists serving and caring for those dependent upon Medicaid for dental care and to make dental care accessible to underserved metropolitan and rural areas. The program provided educational loan repayment assistance for up to four Oklahoma licensed full-time dentists and one full-time equivalent faculty dentist per year, for a two to five year period per dentist. Fifteen practicing dentists and two faculty dentists participated in the program during this period. The Oklahoma State Department of Health (OSDH) Dental Health Service administered this program.

The state legislature appropriated $100,000 to the OSDH to help support the Oklahoma Dental Foundation Mobile Dental Care Program. Using this mobile dental unit, comprehensive dental

treatments were provided to individuals who could not afford dental care and/or who lived in underserved areas of the state. These funds were also administered through the Dental Health Service. Between October 1, 2008 and September 30, 2009, 83 trips were made to locations within Oklahoma, 1,187 volunteer hours were provided to treat 1,074 patients, and the value of the care provided was estimated to be $242,768. Of those 1,074 patients, approximately 68% were under the age of 21 and 26% of those were children eight years old or younger.

MCH continued to work collaboratively with Dental Health Service to educate children, their parents/guardians, and health care providers on oral health, to include the importance of protective sealants. Child health providers assessed teeth during well child exams and referred as indicated. The OSDH School Health Program distributed oral health education material via school newsletters and conferences.

Dental educational services provided by dental health educators included dental health education and tobacco use prevention instruction in 37 counties to 32,647 children, preschool through high school, with an emphasis on reaching those in kindergarten through sixth grades. Topics included appropriate dental hygiene and care of one's teeth, playground safety, the use of mouth guards, dental disease prevention (sealants, fluoridation, regular dental care), and proper nutrition with healthy snacks.

Six county health department clinic sites provided dental services to children. Procedures and services included dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction, and prescriptions for infections. MCH continued to provide funding for dental clinical services.

The Governor's Task Force on Children and Oral Health completed its final phase. The task force determined ways to infuse oral health education, dental care, and dental disease prevention into existing and new programs. Focus areas included fluoridation status of our state, dentistry's role in catastrophic health emergencies, and children with special health care needs. This collaborative effort resulted in the development of a state oral health plan.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted the statewide dental health needs assessment of third grade children				X
2. Supported the placement of dentists in rural areas of state through educational loan repayment program funded through the Oklahoma Dental Loan Repayment Act				X
3. Provided comprehensive dental care to children who could not afford care and/or live in underserved areas of the state through partnership with Oklahoma Dental Foundation	X			
4. Provided dental health education in schools and at child health clinic visits		X		
5. Provided dental clinic services through 6 county health department sites	X			
6. Participated in Governor’s Task Force on Children and Oral Health to finalize a state oral health plan				X
7.				
8.				
9.				
10.				

b. Current Activities
Activities are underway for the 2010 statewide dental health needs assessment of third grade children. Dental Health Service works with the University of Oklahoma (OU) Colleges of Dentistry and Public Health to administer this project. Information obtained from this survey includes dental caries and sealant data.

The Oklahoma Dental Loan Repayment Program is funded with state appropriated funds through June 30, 2010. New state funding for State Fiscal Year (SFY) 2011 was not received from the Oklahoma legislature due to state revenue shortfalls. Existing funding will sustain the 18 active participants for approximately six months into the next SFY. Two participants are faculty members at the OU College of Dentistry.

The first Oklahoma Mission of Mercy (OKMOM) was held February 5-6, 2010 in Tulsa. With the help of hundreds of volunteers, 6,997 dental procedures were performed for 1,805 needy Oklahomans. Planning is underway to host a similar event in Oklahoma City in 2011.

Committees are working to develop strategies for implementing recommendations presented by The Governor's Task Force on Children and Oral Health in its state oral health plan.

Dental educational services in 35 counties and dental clinical services in eight county health department sites continue to be available in the state.

c. Plan for the Coming Year
The dental health needs assessment of third grade children will resume in late 2011 for the 2012 school year and be conducted during the even years. Data will include total caries experience, active decay, and sealant indicators.

An OKMOM will be held in Spring 2011 in Oklahoma City. This will be the second statewide event and involve hundreds of volunteers to provide dental services for approximately 1,800-2,000 needy Oklahomans, to include children. Similar to the last OKMOM, resource booths will be on-site so that participants can be linked to necessary services, such as SoonerCare, Oklahoma's Medicaid Program.

The state level Child Health Advisory Task Force, chaired by staff from the Oklahoma Health Care Authority and the Chief of MCH, will work with the Chief of the Dental Health Service and the Child Health Committee of the Oklahoma Health Improvement Plan (OHIP) on strategies to strengthen integration of children's dental health into medical home activities. The OHIP is a State Fiscal Year (SFY) 2009 legislative mandate that designates the OSDH as the lead agency responsible for developing a plan to improve the overall health status of Oklahomans and report progress to the state legislature.

MCH will assure that oral health is addressed through child health clinics, school health activities and the state plans for early childhood and Head Start.

Dental educational program services and dental clinical services will continue. Educational topics will include appropriate dental hygiene and care of one's teeth, playground safety, the use of mouthguards, dental disease prevention (sealants, fluoridation, regular dental care), and proper nutrition with healthy snacks. Clinical services will include dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction, and necessary prescriptions for infections.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.7	5.5	5	5	5.7
Annual Indicator	4.9	6.7	6.8	6.8	6.8
Numerator	36	49	51	51	51
Denominator	727415	735666	745170	745170	745170
Data Source				Vital records & U.S. Census Bureau	Vital records & U.S. Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.5	5.3	5.1	4.9	4.7

Notes - 2009
Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator. Finalized 2009 death records not yet available, hence provisional 2007 data is used as an estimate.

Notes - 2008
Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator. Finalized 2008 death records not yet available, hence provisional 2007 data is used as an estimate.

Notes - 2007
Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator. Provisional 2007 data used for numerator.

Despite the increase in the death rate of children <15 years of age to motor vehicle crashes in 2006, future rates are expected to remain closer to 5 deaths per 100,000.

a. Last Year's Accomplishments
In 2007, the latest year for which final mortality data are available, there were 51 recorded motor vehicle deaths to children 14 years of age or younger. Approximately 69% of the 51 were riding unrestrained. This resulted in a death rate of 6.8 per 100,000 children in this age group and a small increase from the previous year's rate of 6.7 per 100,000. This should be interpreted cautiously due to the small number of events, which tends to cause volatility in single-year rates. Single-year rates for this measure have varied considerably, making interpretation difficult. The five-year average removes some of this variability. The rate for 2003-2007 was 5.3 per 100,000.

The Child Death Review Board continued to assess multiple variables leading to the death of children including motor vehicle crashes and made the following legislative and procedural recommendations: mandatory sobriety testing of drivers in motor vehicle accidents resulting in a

child fatality and/or a critical or serious injury to a child; banning the use of wireless hand-held telephone or electronic communication devices by drivers; strengthening the booster seat legislation to include use up to age 8; passage of All-Terrain Vehicle (ATV) safety legislation; enforcement of child passenger safety restraint laws; development and dissemination of a campaign promoting the best practices related to booster seat usage; the provision, at no cost, of driver education classes for all high school and career tech students; and increased accessibility and usage of drug courts and drug treatment. The Chief of MCH continued to serve on the Child Death Review Board. The Child Death Review Board continued the statewide media campaign, "Think, Prevent, Live". Motor vehicle deaths were one of the priorities of the campaign.

Safe Kids Oklahoma (Safe Kids) continued as a collaborative project between the Oklahoma State Department of Health (OSDH), University of Oklahoma (OU) Children's Physician's, Children's Hospital at OU Medical Center, Oklahoma Highway Safety Office, and Safe Kids Inc., the private non-profit fund-raising arm of Safe Kids Oklahoma. MCH continued to provide funding to Safe Kids.

Safe Kids began a new effort to measure program outcomes with the assistance of the United Way. The purpose was to improve their ability to effectively plan, implement, evaluate, and communicate results of program initiatives. Safe Kids expected to be able to track the extent to which program participants experienced benefits or changes.

Safe Kids established monthly car seat safety check-ups throughout the western half of the state. The organization sought to increase the support given to rural technicians statewide by notifying technicians of opportunities and trainings they could attend.

Safe Kids continued to offer training statewide in Child Passenger Safety (CPS), primarily targeting health professionals, child care professionals, law enforcement, and firefighters. Six "Introduction to CPS" classes were conducted for 75 participants. Two four-day certification classes were held for 29 participants.

Safe Kids continued to work with the Oklahoma Child Care Services, Oklahoma Department of Human Services (OKDHS), in the requirement of CPS training for all child care centers that transport children. Each center was required to have at least one staff member who transports children complete the eight-hour CPS course. Safe Kids held 16 one-day classes to educate a total of 182 child care providers, health educators, firefighters, emergency medical system (EMS) staff, and home visitation nurses from the Children First Program on the OKDHS rules.

Safe Kids conducted 21 child safety seat checks across the state, checking a total of 345 seats. An additional 143 safety seat checks were conducted through individual appointments. Safe Kids provided 21 discounted car seats, 83 subsidized car seats, and 184 free car seats to families in need. The loaner program for children with special health care needs served 31 children.
The OSDH Injury Prevention Service once again received funding from the Oklahoma Highway Safety Office to implement a car/booster seat program statewide. Approximately 1200 car seats and 600 booster seats were distributed through county health departments.

Quarterly meetings were routinely held between MCH and Injury Prevention to assure collaboration on activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated in Child Death Review Board to contribute to and impact state policy				X
2. Supported statewide activities of Safe Kids Oklahoma through			X	

provision of funding and technical assistance				
3. Continued partnership and quarterly meetings with Oklahoma State Department of Health Injury Prevention Service			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

One of the workgroups for the "Preparing for a Lifetime; It's Everyone's Responsibility", Oklahoma's statewide infant mortality reduction initiative, is focused on injury prevention. This workgroup meets routinely to focus on the reduction of mortality and morbidity of infants up to one year of age, to include those resulting from motor vehicle crashes.

MCH continues to provide support and serve as a resource as Safe Kids looks to increase the presence of Safe Kids activities at the community level across the state. Safe Kids has been able to secure additional funding through fund raising activities this year and with changes in OSDH policies is no longer considered a sole source contract with the contract ending June 30, 2010. With current state budget shortfalls and information from the needs assessment, MCH is reassessing priorities for use of funds for injury prevention and may look to put a Request For Proposal out for services late summer or early fall given funds are available after budget shortfalls are absorbed.

Train-the-trainer efforts are ongoing through the MCH Adolescent Health Coordinator. These trainings focus on the adolescent brain and maturation, youth development and indicators of morbidity and mortality in Oklahoma (including unintentional injury and death - most commonly motor vehicle accidents). Oklahoma has seen deaths of children 14 years and younger resulting from their driving in rural Oklahoma or riding as a passenger with older adolescents.

c. Plan for the Coming Year

MCH, Injury Prevention Service, the OSDH Office of Child Abuse Prevention, and the OSDH Office of Communications will work closely with the Child Death Review Board as the materials for this focus area within the "Think, Prevent, Live" campaign are developed. The Injury Prevention Workgroup will look at how it can build upon the statewide infant mortality reduction initiative as it refines its intervention efforts. In addition, the Oklahoma Highway Safety Office, working with MCH and Injury Prevention Service, has plans to develop posters and brochures with a Graduated Driver's License focus for display and dissemination in state vehicle tag agencies.

The Chief of MCH will serve as the Vice Chair of the Child Death Review Board. This opportunity will provide for additional partnerships in addressing this performance measure.

The Adolescent Health Coordinator will represent MCH on the statewide Injury Prevention Advisory Council. Responsibilities include reviewing proposed legislation and making recommendations to decrease motor vehicle crashes.

Strengthening Safe Kids activities at the community level will continue to be a priority for MCH. MCH and Safe Kids will explore with Turning Point opportunities for prioritizing and integrating Safe Kids activities as part of local coalition agendas. Safe Kids will look to increase support given to rural technicians that have participated in CPS training.

MCH and Injury Prevention Service will continue to strengthen their partnership. Routine joint staff meetings will continue. Injury Prevention Service will support MCH in impacting this measure by providing free child safety seats to eligible families and conducting safety seat checks. Child safety seats will be shipped to 67 county health department locations. Injury Prevention Service will maintain in-kind support to Safe Kids for CPS classes, child safety seat check events, and technical assistance to strengthen and expand services to rural areas.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		31.8	32.4	33.1	30.7
Annual Indicator	31.2	29.6	30.2	30.5	30.5
Numerator			14416	15497	15497
Denominator			47662	50848	50848
Data Source				Oklahoma TOTS survey	Oklahoma TOTS survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	31.2	31.7	32.2	32.7	33.2

Notes - 2009
Source: 2009 data are unavailable, therefore 2008 TOTS survey data is used. Numerator and denominator are weighted population estimates. Oklahoma 2008 TOTS surveyed mothers who completed 2006 PRAMS survey.

95% CI: 26.6%, 34.6%

Notes - 2008
Source: 2008 TOTS survey data. Numerator and denominator are weighted population estimates. Oklahoma 2008 TOTS surveyed mothers who completed 2006 PRAMS survey.

95% CI: 26.6%, 34.6%

Notes - 2007
Source: Oklahoma 2007 TOTS survey of mothers who completed 2005 PRAMS survey. Numerator and denominator are weighted population estimates.

a. Last Year's Accomplishments
Data from The Oklahoma Toddler Survey (TOTS) in 2008, which provides state-specific information on breastfeeding at six months postpartum, revealed that 30.5% of Oklahoma

mothers breastfed their infants to at least 6 months of age and 12.1% breastfed for 12 months or longer. The data were not statistically different from 2007 rates.

MCH monitored breastfeeding initiation, duration and exclusivity using data from the Pregnancy Risk Assessment Monitoring System (PRAMS), Women, Infants and Children Supplemental Nutrition Program (WIC), TOTS and National Immunization Survey (NIS). This information was shared with state policymakers, health care providers, families, and community groups.

MCH provided leadership for the Oklahoma State Department of Health (OSDH) initiative recognizing breastfeeding friendly employers and worksites. Employer brochures with minimum criteria for recognition, decals stating that nursing mothers and babies are welcome in Oklahoma businesses, and legislation cards summarizing Oklahoma's Breastfeeding Laws were posted on the OSDH Breastfeeding Information and Support web site, http://www.ok.gov/health/Child_and_Family_Health/Breastfeeding_Information_and_Support/. Additional worksites met established criteria and received certificates as Oklahoma Recognized Breastfeeding Friendly Gold Star Worksites, bringing the total number to 19.

MCH and OSDH Human Resources provided information about the OSDH employee breastfeeding room in new employee orientations and on bulletin boards throughout the agency. The breastfeeding room was showcased as a model for other state and community agencies, along with the benefits it provided for employers and families in support of nursing mothers returning to work.

In working with MCH, the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, posted on their website a listing of 21 Oklahoma International Board Certified Lactation Consultant (IBCLC) providers who had contracts with Medicaid for provision of lactation support services to pregnant and postpartum females. This benefit was shared with health care providers through their professional organizations as well as direct provider communications from the OHCA.

MCH participated in the WIC Breastfeeding Task Force in planning the WIC's annual breastfeeding symposium for health care providers, "Breastfeeding from Baby's Point of View", featuring Kittie Frantz, RN, CPNP-PC and Christina M. Smillie, MD, FAAP, IBCLC, FABM. The task force helped create English and Spanish breastfeeding public service announcements, aired before, during, and after World Breastfeeding Week, with donated airtime, and also reviewed state and community news releases. During World Breastfeeding Week, WIC clinics hosted receptions honoring breastfeeding moms, organized walks, displayed and shared promotional posters, bags with promotional messages, and informational materials that offered ways to support nursing mothers and increase breastfeeding rates.

The Breastfeeding Workgroup of the "Preparing for a Lifetime, Its Everyone's Responsibility", the statewide infant mortality reduction initiative, promoted breastfeeding through activities targeting African American and American Indian women and teens and included promotion and support for creation of an IBCLC staffed Oklahoma Breastfeeding 24-hour Hotline (1-877-271-MILK) for nursing mothers, expecting parents, and health care providers. The hotline was a partnership of MCH, WIC, the University of Oklahoma (OU) Medical Center and OU Health Sciences Center Department of Obstetrics and Gynecology (OB/GYN). A breastfeeding brochure for the public,"Nursing Your Newborn", was also developed. The workgroup explored increasing breastfeeding education in health professional training programs.

A breastfeeding question and information section was developed for the nutrition history portion of the Preconception Care Women's Health Checklist, a self-assessment tool developed by the Preconception/Interconception Care and Education Workgroup of the statewide infant mortality reduction initiative. Each section of the tool listed important questions to consider prior to or between pregnancies and included brief information for each question. Breastfeeding information was also included in brochures and online trainings for nurses and child care providers on infant

safe sleep.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided education and data about breastfeeding in Oklahoma to wide audience across the state to promote breastfeeding			X	
2. Provided recognition to breastfeeding friendly employers and worksites			X	
3. Showcased OSDH employee breastfeeding room as model for other state and community agencies				X
4. Collaborated with the OHCA on policy changes to strengthening availability of certified lactation consultants				X
5. Partnered with WIC and OU Medical Center and Department of OB/GYN to support statewide 24/7 Breastfeeding Hotline			X	
6. Assured inclusion of breastfeeding in Preconception Care Women's Health Checklist			X	
7.				
8.				
9.				
10.				

b. Current Activities

Media coverage for breastfeeding increased with a local television news interview of the Breastfeeding Hotline Coordinator in response to breastfeeding and flu. A follow-up OSDH news release "Breastfeeding Protects Babies During Flu Season" was published and information placed on the OSDH breastfeeding website.

The Breastfeeding Friendly Worksite Initiative was reviewed in several newspaper articles, including pictures and stories from Gold Star worksites.

The OHCA has collaborated with MCH, WIC, and the Central Oklahoma Breastfeeding Advocates (COBA) to increase the number of Oklahoma IBCLC providers who have contracted with Medicaid to provide lactation support services to pregnant and postpartum females. The OHCA website now lists 34 IBCLC providers.

MCH, WIC, and OSDH Chronic Disease Service are working with the COBA to develop a PowerPoint presentation for nursing faculty use in their teaching of nursing students on supporting breastfeeding.

WIC's Breastfeeding Peer Counselor Program has expanded to include 26 peer counselors working in 21 sites in 13 counties.

The OSDH breastfeeding website serves as a statewide breastfeeding resource, with the recent addition of four pages, "Frequently Asked Questions", "H1N1 Flu/Seasonal Flu and Breastfeeding Your Baby", "Just 4 Teens", and "Breastfeeding in Emergencies".

c. Plan for the Coming Year

Breastfeeding rates will continue to be monitored through PRAMS, WIC, TOTS, and NIS data and information shared with state policymakers, health care providers, families and community

groups.

MCH will promote the OSDH Breastfeeding Friendly Worksite Initiative through Turning Point's Certified Healthy Business e-mails and annual conference, the Oklahoma Healthy Mothers Healthy Babies annual conference, the OSDH breastfeeding website, the annual WIC Breastfeeding Symposium, and statewide news releases and trainings.

MCH and WIC will continue the partnership with OU to maintain support for the 24/7 Oklahoma Breastfeeding Hotline. The support line will be promoted during training of health care professionals, services to pregnant and breastfeeding females, and through the media. MCH will work with WIC to identify sites for expansion of the Breastfeeding Peer Counseling Program.

Through a MCH contract starting July 1, 2010, the OU Office of Perinatal Continuing Education (OPCE) will provide evidence-based breastfeeding training over the next two years to Oklahoma birthing hospitals using American Recovery & Reinvestment Act (ARRA) grant funding.

Discussion with the OHCA will explore ways to promote the Baby-Friendly designation for Oklahoma hospitals. Part of these discussions will also focus on the feasibility of developing Medicaid policy to extend outpatient lactation benefits from mother to infant so services can be provided to breastfeeding infants older than 60 days.

MCH will work with WIC's Breastfeeding Task Force to plan the 2011 Annual WIC Breastfeeding Symposium for health care providers. The task force will coordinate World Breastfeeding Week activities, review breastfeeding promotion materials for county health departments and area clinics, and plan for upcoming trainings, including breastfeeding education and lactation management courses.

Through the "Preparing for a Lifetime, It's Everyone's Responsibility", MCH will partner with the OPCE, OHCA, Oklahoma Hospital Association (OHA), and March of Dimes to establish and develop the Oklahoma Maternal-Infant Quality Care Collaborative in an effort to provide safe, quality maternal and infant care by providing or linking health care professionals, hospitals, and providers to educational tools and best practice resources. Breastfeeding will be one of the initial focuses with the Breastfeeding Workgroup taking the lead on these activities.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96.6	97.2	95.1	95.5	97
Annual Indicator	94.6	95.1	95.1	96.8	96.8
Numerator	49001	51352	52262	52980	52980
Denominator	51775	54010	54946	54753	54753
Data Source				Screening and Special Services, OSDH	Screening and Special Services, OSDH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97.2	97.4	97.6	97.8	98

Notes - 2009
Source: Data were obtained from Screening and Special Services, OSDH. Data not yet available for 2009, hence 2008 data are used as a provisional estimate.

Notes - 2008
Source: Data were obtained from Screening and Special Services, OSDH. Year 2008 data are provisional estimates.

By 2011 auditory screening machines will electronically transmit results from hospital newborn screenings to OSDH database, which will reduce clerical errors and thus increase the reported % of newborns receiving hearing screenings.

Notes - 2007
Source: Data were obtained from Screening and Special Services, OSDH. Year 2007 data are not yet available. Therefore, year 2006 is repeated to provide an estimate.

a. Last Year's Accomplishments
Of the 54,753 Oklahoma births in calendar year (CY) 2008, 52,980 infants (96.8%) had hearing screened prior to hospital discharge, while only 755 (1.4%) were not screened at any time. Of the infants screened, 2,607 (4.8%) were referred for diagnostic assessment for failing the hospital screen and 94 had confirmed hearing loss. Sixty (64%) of those children were diagnosed with hearing loss and amplified by the first month of life. Due to the presence of hearing "risk indicators," 2,607 infants who passed screening at birth were referred for additional hearing screening when they reached six months of age. At least 80 infants with a diagnosis of hearing loss born in 2008 were enrolled in Oklahoma's 0-3 early intervention program, SoonerStart, or other related programs as of February 1, 2009.

The Newborn Hearing Screening Program (NHSP) continued to work closely with all Oklahoma birthing hospitals to ensure initial and follow-up hearing screenings for all infants. As of September 30, 2009, all sixty-nine (69) Oklahoma birthing facilities were providing physiologic hearing screening. All hospitals utilized newly replaced equipment to complete an automated auditory brainstem response (AABR) screening with the exception of one federally funded hospital that utilized otoacoustic emissions (OAE) tests. However, due to high referral rates, the hospital began working towards purchasing an AABR screener. Training on screening and reporting was made available to all birthing hospitals' relevant staff members.

With support through a Health Resources and Services Administration (HRSA) grant (April 2008 - March 2011), the NHSP funded the Universal Newborn Hearing Screening Project and a Follow-up Coordinator was retained as staff of the NHSP. Primary responsibilities of the Follow-up Coordinator included engaging birthing hospitals, parents, and other interested stakeholders to increase utilization of follow-up services and to decrease loss to follow-up and loss to documentation. A new Follow-up Coordinator with a Clinical Doctorate of Audiology was hired in July 2009. This enabled the NHSP to move toward reaching the national goals that every newborn is screened within their first month of life, infants with loss are diagnosed by three months, and infants with loss are enrolled in intervention by six months of age.

Though the Oklahoma NHSP has made tremendous efforts to screen and follow all births in Oklahoma, the need for additional quality assurance and surveillance measures was identified to reduce the number of infants who were lost to follow-up and results that were lost to

documentation. To address these needs, the NHSP applied for a new grant from the Centers for Disease Control and Prevention (CDC) and on September 1, 2009, was awarded funds that provided for a Quality Assurance/Data Coordinator position and an update to the current data tracking system. This position was created to work with all Oklahoma birthing hospitals to assess compliance of state mandated newborn hearing screening reporting as well as analyze sites' referral rates to ensure results were within normal limits set by the equipment manufacturer. The data tracking update was designed to provide direct input from the hospital screening equipment daily. The NHSP worked closely with the Information Technology program at the Oklahoma State Department of Health (OSDH) and Neometrics software developers to create a pilot project to ensure safe and secure data transfer.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided timely screening for newborn hearing and needed follow-up services statewide			X	
2. Provided education and training to health care providers				X
3. Hired a Follow-up Coordinator to decrease loss to follow-up and loss to documentation			X	
4. Sought and obtained a CDC grant to provide the NHSP with a Quality Assurance/Data Coordinator and for changes to software to improve data transfer/tracking				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The NHSP is purchasing new follow-up screening equipment for 11 county health departments. The new devices allow for both AABR and OAE screening. OSDH audiologists have conducted a trial to assure that the new equipment provides adequate results.

The CDC funded projects continue. The Quality Assurance/Data Coordinator position was filled in November 2009. The data tracking update has a pilot project scheduled in Summer 2010 with St. Johns Medical Center in Tulsa.

Due to agency travel restrictions and reduced staff, the Early Intervention Task Force led by the state early intervention program has been placed on hold. Therefore, the NHSP and Oklahoma Audiology Task Force (OKAT) are collaborating to provide a broader outreach for families of children with hearing loss and those who provide them with audiological services. The OKAT revised and disseminated the Oklahoma Protocol for Infant Audiologic Diagnostic Assessment. This document compiles national standards from the Joint Committee on Infant Hearing, the American Speech-Language Hearing Association, and the American Academy of Audiology. The OKAT is working on increasing task force membership and has developed five subcommittees in which members can participate. Currently, there are four times as many participants than in the previous years. The subcommittees include Outreach to Pediatric Audiologists, Outreach to Other Medical Providers, Family Support, Genetics, and Protocols/Guidelines/Data/Outcomes.

c. Plan for the Coming Year
The statewide NHSP will continue to seek ongoing support and assistance from the MCH and CSHCN programs. As in the past, the collaborative efforts will assure that all Oklahoma newborns meet or exceed the national goals of having their hearing screened within the first month of life, and if hearing loss is suspected, diagnosis and intervention are provided for the infant in a timely manner.

With funding from the HRSA grant, additional hearing screening equipment will be made available to health departments in rural areas. More than 60 sites including health departments and early intervention locations will be equipped and trained to provide follow-up screening for infants who did not pass the hospital screen, were not screened prior to discharge, and/or have conditions warranting the need for hearing re-screening at specific intervals. Training in the use of screening equipment will be provided to all clinicians during the upcoming grant period utilizing video conferencing capabilities.

The CDC funded Quality Assurance/Data Coordinator will develop and conduct epidemiologic processes related to surveillance, data collection, and data analysis to improve annual reporting and quality assurance. The data tracking update and planned modifications to the NHSP Neometrics database system will enable the program to better track results, increase efficiency of data transfer, reduce staff time needed to confirm information received, and eliminate unnecessary paperwork. Grant-funded software updates will provide daily electronic reporting of screening results to the NHSP for all infants born at an Oklahoma birthing hospital via each hospital's hearing screener. By receiving results directly from the screeners, the number of infants lost to documentation should be reduced.

One future goal of both the NHSP and the Newborn Metabolic Screening Program is to purchase and utilize the Neometrics web-based data reporting software. This will allow electronic reporting of follow-up screening and diagnostic results back to the newborn screening programs in a secure fashion. The Oklahoma programs will work with states that have already implemented this software to get feedback on lessons learned. This software will allow authorized providers (physicians, audiologists, and other health care providers) to obtain initial screening and follow-up screening results on a secure website for continuity of care.

The OKAT will continue to meet four times a year. To increase statewide participation, three options for participation will be available including in-person attendance, videoconferencing, and telephone conferencing. Additional efforts will be placed on outreach to medical providers, early interventionists, families, and self advocates. Each subcommittee will meet monthly via telephone conference under the facilitation of the NHSP to define the mission of the group and address activities developed by the team.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.7	17.8	13.9	12.4	12.5
Annual Indicator	14.0	12.5	12.5	12.6	12.6
Numerator	127190	114000	114000	116000	116000
Denominator	910660	913000	913000	920000	920000
Data Source				U.S. Census Bureau	U.S. Census Bureau
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12.4	12.3	12.2	12.1	12

Notes - 2009
Sources: U.S. Census Bureau, Current Population Survey. Final 2009 data are not yet available, hence 2008 data are used as a provisional estimate.

Notes - 2008
Sources: U.S. Census Bureau, Current Population Survey.

Notes - 2007
Sources: U.S. Census Bureau, Current Population Survey. Current 2007 data not yet available, therefore 2006 numbers used as an estimate.

The 2008-2012 future annual performance objectives have been revised to a conservative estimate of the % uninsured children given current economic conditions in Oklahoma.

a. Last Year's Accomplishments
Data obtained from the U.S. Census Bureau revealed that 12.6% of all Oklahoma children ages 0-18 were uninsured during calendar year 2008, higher than the national average of 11.0% of uninsured children ages 0-18. Approximately 116,000 children were uninsured in the state of Oklahoma.

During the 2009 legislative session, MCH provided information and education to support passage of several measures to increase access to health care in the state. These measures included provisions of insurance coverage of expenses associated with the treatment of autism, support of the children's behavioral health initiative, increased access to health care through workforce development, and implementation of a requirement for health education in schools. While many of the measures were unsuccessful, the legislature approved a five-part approach to increasing qualified therapists for autism and minimal funding for children's behavioral health.

The Electronic Newborn-1 (eNB-1) continued to be implemented across the state in birthing facilities. The electronic process allowed infants to receive an identification (ID) number and be assigned to a primary care provider in SoonerCare, the state Medicaid program, before being discharged from the hospital. The ID card and information about the baby's benefits were printed out for the parent to take home.

Oklahoma submitted a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) to expand coverage of children from 185% up to 300% of the federal poverty level (FPL) through the Insure Oklahoma, Employer Sponsored Insurance Program (ESI) and Individual Plan (IP). ESI helped small businesses and their qualified employees afford health insurance by paying 60% or more of the insurance premiums. IP provided assistance to individuals who did not qualify for the ESI. These individuals had to work for a small business eligible for the program or had to be temporarily unemployed and eligible for unemployment benefits. The Oklahoma State Legislature had already authorized coverage of children up to 300% FPL through Insure Oklahoma with the next step being approval by CMS.

On January 1, the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, implemented a new model of service provision through SoonerCare moving from a partially

capitated program to a patient-centered medical home (PCMH). The model incorporates a managed care component with traditional fee-for-service and provider incentive payments. The model has 3 tiers providers choose from to identify the level of medical home they will provide. A set fee is received for care coordination based on the tier chosen.

MCH continued to partner with the OHCA to facilitate the Child Health Advisory Task Force with its emphasis on several child health priority topics to include online enrollment, the patient-centered medical home model, the OHCA periodicity schedule, and child health quality measures. Input from the task force assisted in guiding policy and system changes necessary for improving children's health.

The MCH Early Childhood Comprehensive Systems (ECCS) project partnered with Smart Start Oklahoma and the OHCA to develop a SoonerCare Toolkit with an overarching goal of increasing the enrollment of and utilization by pregnant women and young children of SoonerCare. Approximately 36 toolkits were distributed to stakeholders in August 2009.

MCH staffed, as well as participated as an expert member of the Child Health Committee of the Oklahoma Health Improvement Plan (OHIP), a legislatively mandated activity that designates the Oklahoma State Department of Health (OSDH) as the lead agency responsible for developing a plan to improve the overall health status of Oklahomans. Insurance coverage is one of many issues being addressed through this work.

County health departments and MCH contract providers provided families with information on Medicaid benefits and assisted families with application completion. Clinical child health services were provided as a safety net service through county health department sites and MCH contract providers. Services included the provision of well child exams, treatment of minor acute illnesses, follow-up metabolic and newborn hearing screening, lead screening, and enabling services as needed. These services were provided in accordance with the American Academy of Pediatrics Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided information and education to policymakers to assist with passage of state measures to increase access to health care				X
2. Provided input as eNB-1, electronic enrollment of newborns at hospitals, was implemented				X
3. Partnered with the OHCA on development of policy and implementation planning of online enrollment, the patient-centered medical home model, the periodicity schedule and quality improvement activities				X
4. Partnered with Smart Start Oklahoma and the OHCA to develop an outreach and information toolkit to increase enrollment in and utilization of Medicaid		X		
5. Provided support and served as an expert member of the Child Health Committee of the OHIP				X
6. Assisted families to enroll in Medicaid		X		
7. Served as safety net provider for child health services	X			
8.				
9.				
10.				

b. Current Activities

Oklahoma received approval for its state plan amendment from CMS to expand coverage of children to 300% FPL through Insure Oklahoma. The amendment covers children younger than age 19 in families with workers from any size business whose household income is 185% to 300% FPL. The family's financial responsibility for coverage will not exceed 5% of their household income. At the same time as implementation is being planned for this expansion using state funds specifically designated by the legislature, a 3.5% cut in Medicaid provider rates has been implemented due to state revenue shortfalls. This has led the OHCA to implement the expansion in steps. July 1 is the first date individuals participating in ESI and IP whose income is between 185% and 200% FPL will be offered enrollment opportunity.

Based on a 2009 MCH Title V Block Grant Review recommendation, MCH and CSHCN have sought to strengthen collaboration via face-to-face meetings and technical assistance to the network of federally qualified health centers (FQHCs). It is anticipated this effort will be assisted through quarterly conference calls led by the federal Region VI Office that include MCH, CSHCN, the Oklahoma Primary Care Association and the Office of Primary Care.

The Title V Five Year Needs Assessment is informing the activities of the Child Health Flagship of the OHIP. Data and information are providing a strong basis for development of the comprehensive state plan for improving the health of children.

c. Plan for the Coming Year

The eNB-1 will continue to be implemented with hospitals across the state. In addition, it is expected that online enrollment being implemented this summer for all individuals and families potentially eligible for Medicaid will facilitate the approval process and timely coverage. Also, the OSDH and OHCA will explore the possibility of expanding a pilot where staff have been hired by county health departments specifically to assist individuals and families with applying for Medicaid benefits. The OHCA is providing Medicaid administrative match funds for these positions.

As part of the MCH ECCS project activities and state plan, partnerships with stakeholders and early childhood providers will be used to share information with families on the changes with Medicaid and assist with accessing health care coverage. The SoonerCare Toolkit will be continue to be provided accompanied by specific information on the contents and use of the toolkit.

A Consumer Advisory Committee will be formalized by the OHCA. The OHCA, having seen the value of having families actively participate in the Perinatal Advisory Task Force and Child Health Task Force, has subsequently engaged in discussions and planning with the Executive Director of the Oklahoma Family Network to develop the committee. The committee will provide another opportunity for family input concerning state Medicaid policy.

Efforts will continue to engage the FQHCs in more routine interactions so mutual goals and priorities of improving children's health can be enhanced through ongoing sharing of information and collaboration. The Chief of MCH and Director of the CSHCN Program have requested to attend quarterly meetings the Oklahoma Primary Care Association facilitates with FQHC Directors and Clinic Administrators as a first step.

County health departments and MCH contractors will continue to serve as safety net providers for health care services to children using the American Academy of Pediatrics Bright Futures Guidelines. Both county health departments and MCH contractors will provide information and assistance to families seeking information on health benefits for children.

MCH staff will continue to provide leadership and staff support to the Child Health Flagship of the

OHIP. The comprehensive state plan for improving children's health will be finalized and submitted to the Governor and Legislature.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		50.2	53.9	53.3	52.3
Annual Indicator	51.3	54.4	54.4	17.9	17.4
Numerator				10495	10029
Denominator				58778	57591
Data Source				Oklahoma WIC	Oklahoma WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17.3	17.2	17.1	17	16.9

Notes - 2009
Source: 2009 Oklahoma WIC data. Given that SLAITS discontinued the WIC participation question following the 2003 SLAITS survey, OSDH will use data from Oklahoma WIC office effective CY2010.

OK WIC does not collect 85th percentile BMI information on clients, hence 95th percentile BMI data will be used henceforth.

Notes - 2008
Source: 2008 Oklahoma WIC data. Given that SLAITS discontinued the WIC participation question following the 2003 SLAITS survey, OSDH will use data from Oklahoma WIC office effective CY2010.

OK WIC does not collect 85th percentile BMI information on clients, hence 95th percentile BMI data will be used henceforth.

Notes - 2007
Source: Data were obtained from the NCHS SLAITS dataset for the National Survey of Children's Health. This national survey provides state-specific estimates for the proportion of children aged 2-5 receiving WIC benefits. Numerator and denominator data are unavailable. 2007 data not available, hence 2006 numbers used as an estimate.

a. Last Year's Accomplishments
The Women, Infants and Children Supplemental Nutrition Program (WIC) reported that the percent of children ages 2 to 5 years, receiving WIC services through the Oklahoma State Department of Health (OSDH) with a body mass index (BMI) at or above the 95th percentile was 17.4% in 2009. Due to changes in the National Survey of Children's Health, data are no longer available about children ages 2 to 5 receiving WIC with a BMI at or above the 85th percentile.

OSDH WIC captures only those at or above the 95th percentile.

WIC continued to monitor BMI status for children ages 2 to 5 years and required reduced, low and non-fat food options beginning on August 1, 2009. In addition, fruit, vegetables, and whole grains were added to the WIC food package. The new food package aligned with the 2005 Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics. The Oklahoma WIC food package had reduced amounts of milk, cheese, eggs, and juice and eliminated whole milk for participants over two years of age.
Policy, implementation, and statewide training for the new WIC food package were completed. Food package education materials continued to be developed. Oklahoma encouraged the development of healthy weights in WIC families through increased intake of fruits and vegetables and the use of reduced, low and non-fat dairy products in planned meals. Increased active play and physical activity was also emphasized. "Cooking with WIC" reinforced positive family nutrition by using video field trips and cooking demonstrations to help WIC participants improve their skills in purchasing, planning, and preparing nutritious meals and snacks to improve the family diet.

WIC promoted the continued expansion of professional development, education, and training of staff through various multi-media, web-based training, online training, and local, state, and national conferences. The WIC Training Link (www.ok.gov/wic) provided up-to-date online trainings and information to local, state, and national WIC staff. The WIC Training Course was accompanied by activities, quizzes, and assignments to reinforce the subjects of the course and to develop skills used in the WIC clinic. Policy, procedure, and additional trainings continued to be developed to expand, train, and educate all WIC staff as well as other OSDH staff: clerical, paraprofessional, and professional.

WIC's efforts to promote and support breastfeeding showed results with almost an 8% increase in breastfeeding initiation rates in the last 5 years (67.1% in 2004 to 75.0% in 2009). In addition, the WIC Breastfeeding Peer Counseling Program expanded and succeeded in increasing breastfeeding initiation rates in the counties served by the Breastfeeding Peer Counseling Program. Breastfeeding peer counselors worked in Lincoln, Logan, Kingfisher, Blaine, Canadian, Comanche, Leflore, McIntosh, and Haskell counties. The combined initiation rates in those nine counties increased from 64.0% in 2004 before implementation to 72.9% in 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitored BMI status of all children ages 2-5 receiving WIC			X	
2. Introduced new WIC food package that aligned with 2005 Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics				X
3. Promoted development of healthy weights, increased active play and positive family nutrition in WIC participants through use of video field trips and cooking demonstrations			X	
4. Provided trainings for health care providers				X
5. Supported breastfeeding as a priority through expansion of WIC peer counselor program				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Registered/licensed dietitians are available for children and family members identified with BMIs = 95th percentile. A full dietary assessment including family-friendly feeding dynamics and dietary patterns is completed.

WIC continues to provide the new food packages high in fiber and low in fat. Breastfeeding mothers now have a larger variety of canned fish. Whole milk is no longer available for participants over two years of age and the amount of juice provided decreased for children and is eliminated for infants.

Breastfeeding continues to be a priority focus area. There are currently 18 International Board Certified Lactation Consultants providing support to breastfeeding mothers in WIC clinics. WIC hosted the Annual WIC Breastfeeding Educator Course in March 2010 and continues to provide support through the WIC breast pump program.

WIC hosted a 5-day Lactation Educator Course in April 2010. This course was provided for health care professionals who wish to broaden their breastfeeding knowledge and improve their skills working with breastfeeding families. In June 2010, health care providers statewide had the opportunity to attend the Annual WIC Breastfeeding Symposium.

WIC provides a breastfeeding education bag to all pregnant participants. Oklahoma WIC partners with MCH to support the Oklahoma Breastfeeding Hotline (see NPM #11).

Policy and procedures related to registered/licensed dietitians and individual counseling are in draft form and currently being piloted.

c. Plan for the Coming Year

The Annual Nutrition/WIC Conference 2011 will address nutrition education. Oklahoma City Mayor Mick Cornett has committed to discuss his "fitness challenge". The challenge encourages not just individuals, but businesses and community organizations to step up efforts for fitness and health among adults and children.

WIC will continue to produce a "Cooking with WIC" lesson annually. "Cooking with WIC" is a video lesson plan featuring one of Oklahoma's WIC nutritionists preparing meals and snacks using WIC foods. This will allow clinics to show cooking and meal preparation demonstrations even if their facilities do not allow for these to be performed on site. The 2010 "Cooking with WIC" video lesson plan will detail making full meals with the new WIC food package, including whole grains, beans, fresh fruits, and vegetables.

Conclusions from evidence-based reports and reviews suggest a history of breastfeeding is associated with the reduction in the risk of obesity in later life therefore breastfeeding will continue to be a priority focus area for WIC. Strategies to increase breastfeeding initiation and duration rates among Oklahoma mothers will continue to be explored, including through the influence of peer support. The Breastfeeding Peer Counseling Program will continue in the existing sites with breastfeeding peer counselors throughout the state. In addition, the Breastfeeding Peer Counseling Program is in the process of expanding to additional sites, including the Tulsa Health Department.

WIC will continue to provide breastfeeding educational opportunities in 2011 to WIC staff and health care providers by hosting the annual Breastfeeding Educator Course and the Annual Breastfeeding Symposium.

The Oklahoma Breastfeeding Hotline and the OSDH Breastfeeding web page will continue to be supported and promoted by WIC. WIC also plans to continue to provide breast pumps and breastfeeding education bags to help mothers continue to breastfeed and thus increase

Oklahoma's breastfeeding duration rates.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		18.8	18.6	18.4	21
Annual Indicator	19.6	19.3	21.3	16.9	16.9
Numerator	10027	9953	11101	8797	8797
Denominator	51157	51500	52148	52000	52000
Data Source				PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20.5	20	19.5	19	18.5

Notes - 2009
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS).

Data for year 2009 have not been released to date, hence PRAMS survey data for 2008 have been used to provide an estimate for this measure.

Numerator and denominator consist of weighted counts.

2007 95% CI: (18.3%, 24.6%)
2008 95% CI: (14.3%, 19.9%)

While there was a statistically significant decrease in the maternal smoking rate during pregnancy reported in PRAMS, from 21.3% in 2007 to 16.9% in 2008, there has been considerable variability in this measure in 1996-2008, during which period there is no detectable negative trend in the smoking rate. Hence the current annual performance objectives will not be adjusted. With the launch of the Preparing for a Lifetime initiative in Oklahoma, plus the Tobacco Program's quitline and TV spot, modest improvements for this performance measure are expected in the future.

Notes - 2008
Source: 2008 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS).

Numerator and denominator consist of weighted counts.

2007 95% CI: (18.3%, 24.6%)
2008 95% CI: (14.3%, 19.9%)

Notes - 2007

Source: Data for this performance measure are drawn from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2007. Numerator and denominator consist of weighted counts.

a. Last Year's Accomplishments

Monitoring data provided by the Oklahoma State Department of Health (OSDH) Pregnancy Risk Assessment Monitoring System (PRAMS, 2008) show that 16.9% of pregnant females reported smoking during the third trimester of pregnancy. This is a decrease compared with PRAMS data for year 2007 in which 21.3% of pregnant females reported smoking in the last three months of pregnancy, however the decline was not statistically significant. Overall, since year 2000, when it was 16.9%, the rate of smoking during pregnancy has remained the same, although it has not been monotonic. In 2001, the rate rose to 20.3%, then dropped to 16.2% in 2003, rose again to 19.6% in 2005, then dropped to 16.9% for 2008.

The Oklahoma Health Care Authority (OHCA)/OSDH (MCH) Perinatal Advisory Task Force moved into its fourth year of facilitating systems changes to improve perinatal care. This year the focus of activities continued to be on quality improvement. MCH and the OHCA adopted a policy change in 2008 allowing Medicaid providers to receive separate compensation for completing the Psychosocial Risk Assessment and for counseling clients on the "5 A's" for tobacco cessation. Providers were informed of these benefits and how to bill for provision of the services through onsite technical assistance visits, phone consultation, and written information.

The Oklahoma State Plan for Tobacco Use Prevention and Cessation was published with input from key MCH stakeholders. The plan provided detailed information about the effect tobacco use has on reproductive health, the fact that smoking during pregnancy causes low birth weight infants, miscarriages, premature birth, and stillbirth. Discussion began on assuring that the impacts of tobacco use on pregnant women and infants were included in the annual update of the tobacco use prevention social marketing plan.

The Oklahoma Tobacco Settlement Endowment Trust (TSET) authorized the OHCA to proceed with a new grant project that would implement tobacco cessation activities for pregnant females covered by SoonerCare. The project, a collaborative effort between the OHCA and the Iowa Foundation for Medical Care, would use the proven method of one-on-one "Practice Facilitation" and cessation interventions with health care providers to reduce tobacco use by pregnant SoonerCare members. The target population would be pregnant females who smoke and reside in Tulsa and Oklahoma metropolitan areas and providers with at least 40 pregnant SoonerCare members.

Family planning clients and pregnant females seen through county health departments and contract clinics were provided with information on the impact of smoking during the preconception, interconception, and prenatal periods. Females who smoked or reported family members who smoked were referred to the Tobacco Helpline, 1-800-QUIT-NOW, for support in their efforts to discontinue smoking. MCH monitored county health department and contract clinics documentation of smoking intervention for clients who reported using tobacco products for appropriate referrals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported OHCA in maintaining their policy to cover tobacco cessation intervention for pregnant women				X
2. Provided input into Oklahoma State Plan for Tobacco Use Prevention and Cessation				X
3. Began discussions on developing specific messaging focusing			X	

on the impact of tobacco on pregnant females and infants as a priority in tobacco use prevention social marketing plan				
4. Served as resource to the OHCA as the application for TSET funds was developed to implement a SoonerCare pilot project targeting pregnant females who smoke				X
5. Provided education to family planning and maternity clients seen through county health departments and contract providers; referred to Oklahoma Tobacco Helpline	X			
6. Monitored referrals of clients to Oklahoma Tobacco Helpline through review of medical documentation during site visits to county health departments and contract providers				X
7.				
8.				
9.				
10.				

b. Current Activities

The Tobacco Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility" initiative to reduce infant mortality meets every other month to promote communication and collaboration across multiple programs, agencies, and organizations on efforts to promote smoking cessation in pregnant females. A fact page on the effects of smoking during pregnancy and of second hand smoke has been developed for the community toolkit to be ready for use by July 1. Related, this information is also on the initiative's website accessible through the OSDH homepage. Other activities include designing a social marketing campaign to educate high-risk populations (African American and American Indian) on effective cessation treatments and provide motivational messages to encourage them to increase attempts to quit.

The OHCA received TSET funding for the pilot project in providers' offices to counsel pregnant females on the benefits of smoking cessation and offer incentives to quit smoking during pregnancy and to stay quit during the postpartum period. The OHCA/OSDH Perinatal Advisory Task Force serves as the advisory body for the project.

Both MCH and OHCA continue to promote awareness of reimbursement for providers who provide the 5 A's counseling with pregnant females. Discussions are occurring as to how to provide reimbursement for the 5 A's counseling with mothers during visits to physicians seeing their infants so that a continuum of awareness and care is in place.

c. Plan for the Coming Year

The Tobacco Workgroup will continue to meet. This workgroup plans to implement a social marketing campaign to educate high-risk populations on effective cessation treatments and provide motivational messages to encourage them to quit. Plans will include collaborating with the OHCA and TSET on the pilot project in Oklahoma City and Tulsa.

Support will be provided to facilitate the Obstetric Outreach Program provided by the OHCA to all pregnant SoonerCare members to incorporate tobacco cessation services and referrals to the Oklahoma Tobacco Helpline.

The OSDH Tobacco Use Prevention Service will work with the Oklahoma Insurance Department and TSET to promote the adoption of a core health benefit among private insurers that will reimburse health care providers for tobacco cessation services for pregnant women similar to those provided through the OHCA.

Plans will move forward to implement the Maternal-Infant Quality Care Collaborative led by the OSDH (MCH), OHCA, Oklahoma Hospital Association, March of Dimes, and the Office of

Perinatal Continuing Education at the University of Oklahoma Health Sciences Center. This quality improvement project will assist hospitals to receive evidence-based information and tools to intervene in key issues (e.g., tobacco use) affecting infant mortality.

The OHCA/OSDH Perinatal Advisory Task Force will serve as the advisory body for the pilot tobacco cessation project implemented through the OHCA for pregnant and postpartum females with funding from a TSET grant to help families be tobacco free. The first step is tobacco use cessation during pregnancy that is sustained through incentives through the postpartum period. The OHCA/OSDH Child Health Advisory Task Force is continuing to explore policy and budget impacts of extending Medicaid tobacco cessation benefits to mothers who bring infants to child health appointments.

Family planning clients seen through the county health departments and contract clinics will continue to be provided with information on the impact of smoking and referred to the Tobacco Helpline. Maternity providers will continue to assess pregnant women for smoking through use of the Psychosocial Risk Assessment and provide counseling and referral to the Tobacco Helpline as indicated. MCH will continue to promote use of faxed referrals to the Tobacco Helpline in an effort to increase follow-up contact after the initial encounter. By sending the faxed referral, follow-up with the individual will be initiated by a trained smoking cessation counselor and will not be dependent on the individual to call.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.9	10.1	7.9	9.9	11
Annual Indicator	8.0	10.4	7.9	12.7	12.7
Numerator	19	26	20	32	32
Denominator	236697	250816	251911	251880	251880
Data Source				Vital Records & U.S. Census Bureau	Vital Records & U.S. Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10.5	10	9.5	9	8.5

Notes - 2009
Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau. 2009 death data not yet available, hence provisional 2008 data are used as an estimate.

Despite the increase in the adolescent suicide rate from 7.9 deaths per 1,000 in 2007 to 12.7 in

2008, with the degree of variability seen in the past for this performance measure it is felt the current 2010-2014 annual performance objectives are realistic.

2007 95% CI: (4.4, 11.4)
2008 95% CI: (8.3, 17.1)

Notes - 2008
Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau. 2008 data are provisional.

Notes - 2007
Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau.

The 2008-2012 annual performance objectives have been revised to reflect current data.

a. Last Year's Accomplishments
In 2008, Oklahoma recorded 32 suicide deaths to youth aged 15 through 19, resulting in a suicide death rate of 12.7 deaths per 100,000 population. This is an increase from 7.9 in 2007. Year to year changes in the suicide rate should be viewed with some skepticism given the small number of events in this category of death. The five-year rate covering 2004-2008 was 10.0 suicide deaths per 100,000 youth aged 15-19. Trend analysis from the 2003, 2005, 2007, and 2009 Oklahoma Youth Risk Behavior Survey (YRBS) indicated no statistically significant change in the percentage of students who made a suicide attempt during the past 12 months, made an attempt plan, or seriously considered suicide.

The MCH Adolescent Health Coordinator provided representation on the Oklahoma Suicide Prevention Council, of which, youth suicide prevention was a major focus. The council was renamed per Oklahoma State Statute to the Oklahoma Suicide Prevention Council in an effort to address suicide in Oklahoma across the life span, effective November 2008. The legislation also extended the duration of the council's existence and made modifications to membership and duties of the council. New legislative appointments were made to the council and by-laws were finalized and approved.

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), the lead agency for the state's suicide prevention efforts, was re-awarded the Garrett Lee Smith Grant through 2011 from the Substance Abuse and Mental Health Services Administration (SAMHSA) with emphasis to remain on implementation of evidence-based suicide prevention programs in local communities, tribal entities, and institutions of higher learning for youth ages 10-24, as well as coordination of prevention efforts statewide, strengthening collaboration among key stakeholders, evaluation of effectiveness, and development of a sustainability plan. MCH served as a resource to the ODMHSAS and participated as work began on development of a state suicide prevention plan.

Numerous Question, Persuade, Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST) gatekeeper trainings were provided throughout the state to school personnel, hospital staff, county health department staff, tribal entities, and faith-based organizations. To date, there have been thousands of individuals trained in QPR with over 280 trainers available statewide. A Youth Suicide Prevention Community Toolkit was developed and made available to community coalitions upon request. In June 2009, the Adolescent Health Coordinator completed the two-day ASIST workshop. In September 2009, the second annual "Out of the Darkness" walks, created to emphasize suicide awareness and prevention, were held in the two largest metro areas of the state.

Fact sheets were developed from the 2003, 2005, and 2007 Youth Risk Behavior Survey (YRBS) data, which illustrated state trends in youth suicide ideation and depression. Dissemination was

through a broad audience of stakeholders to include school personnel, mental health providers, and youth serving organizations.

In January, MCH received the final report of Oklahoma's Adolescent Health System Capacity Assessment, a process designed to improve our state's system to achieve critical objectives and public health quality for this population. As a result of this process, participants prioritized adolescent key health issues that are to be the basis for development of a conceptual framework and state plan for adolescent health.

The Adolescent Health Coordinator provided presentations at state agency conferences and to Children's Justice Center staff, schools, churches, and the Region VI Title V Directors on adolescent brain development, maturation, and the unique physical and mental health needs of this population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained involvement with the Oklahoma Suicide Prevention Council				X
2. Served as a resource to the ODMHSAS				X
3. Assisted in the provision of QPR and ASIST trainings through the state				X
4. Assisted in the development of a community toolkit to facilitate community-based youth suicide prevention activities				X
5. Developed fact sheets showing trend data from YRBS on youth suicide ideation and depression and shared with partners and stakeholders			X	
6. Received final report on Oklahoma's Adolescent Health Capacity Assessment and began using information in planning activities				X
7. Served as resource and provided education on adolescent development to partners and stakeholders			X	
8.				
9.				
10.				

b. Current Activities

With the federal Garrett Lee Smith Youth Suicide Prevention and Early Intervention award from the SAMHSA for 2008-2011, Oklahoma has been able to continue implementation of several recommendations in the state's 2001 state suicide prevention plan including statewide and community-based suicide prevention training, suicide screening for youth, and improved referral networks for youth at risk for suicide.

The Oklahoma Suicide Prevention Council has identified key areas being used to develop a new state plan, "The Oklahoma Strategy for Suicide Prevention". The key areas are aligned with the goals outlined in the national strategy with objectives tailored to address the specific needs of Oklahoma. The public health approach, using a system of defining the problem, identifying causes, and implementing and evaluating evidence-based prevention and early intervention strategies, is the core of Oklahoma's strategy.

c. Plan for the Coming Year

MCH will continue to provide staff support and leadership on the Oklahoma Suicide Prevention Council and technical assistance on use of the Oklahoma Suicide Prevention Toolkit. The toolkit provides community advocates support to develop and implement successful youth suicide prevention initiatives.

MCH will continue to assist the ODMHSAS to meet grant requirements of the Garrett Lee Smith Youth Suicide Prevention and Early Intervention Grant from the SAMHSA. Specific activities will occur through the Oklahoma Suicide Prevention Council and include the development of the state suicide prevention initiative and state plan including statewide and community-based suicide prevention training, suicide screening for youth, and improved referral networks. MCH will support the ODMHSAS on goals focusing on increasing the implementation of evidence-based suicide prevention strategies throughout the state and providing training to local community partnerships to increase community capacity. The overall goals will be to reduce the number of suicide deaths and to reduce attempts among youth ages 10-24.

MCH will continue to collaborate with the Oklahoma State Department of Health (OSDH) Injury Prevention Service and the Oklahoma Suicide Prevention Council to utilize the Oklahoma Violent Death Reporting System in conjunction with prevention activities.

Fact sheets featuring YRBS trend data related to suicide ideation and depression will be updated with 2009 data and disseminated throughout the state to school personnel, clinicians, youth advocate groups, parents, and policymakers.

The Oklahoma Suicide Prevention Council will collaborate with the Oklahoma City Indian Health Institute in hosting the Oklahoma Suicide Prevention Annual Conference. The Adolescent Health Coordinator is serving on the conference sub-committee.

QPR and ASIST efforts will be ongoing to provide targeted training for OSDH advanced practice nurses and public health nurses as well as federally qualified health center (FQHC) staff, school nurses, other school personnel, hospital staff, tribal entities, and faith-based organizations throughout the state.

A preconception assessment tool for adolescents will be developed and piloted through county health department family planning clinics that will include as part of the tool anticipatory guidance regarding stress, depression, and suicide ideology intervention and referral process for adolescents.

The Adolescent Health Coordinator will continue to build infrastructure by developing experts at the community level on the different life stages of adolescence, brain development and maturation, and the link to risk taking behaviors, including depression, suicide ideology, attempts, and completion.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80.3	75.5	77	83	83.5
Annual Indicator	73.4	82.1	78.7	80.8	80.8
Numerator	545	724	637	631	631
Denominator	743	882	809	781	781
Data Source				OSDH Vital Records	OSDH Vital Records

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	82	82.5	83	83.5	84

Notes - 2008
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Finalized 2008 data are not yet available, therefore 2007 data are used as a placeholder.

Oklahoma hospitals w/ NICU facilities:

Norman Regional Hospital
Integris Baptist Medical Center
Mercy Health Center
OU Medical Center
Hillcrest Medical Center
OSU Medical Center
Saint John Medical Center
Saint Francis Hospital

Notes - 2007
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from Oklahoma vital statistics.

a. Last Year's Accomplishments
In Oklahoma for 2008, 80.8% (631/781) of infants born weighing less than 1,500 grams were delivered at high-risk facilities. This is an increase in the rate reported for 2007 (78.7%). In 2000, approximately three-fourths (75.7%) of very low birth weight births occurred at high-risk facilities.

MCH provided data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and vital records through a variety of means (PRAMSGRAMs, presentations, trainings, etc.) to educate the public, health care providers, and policymakers on health issues to include health care access and disparities of Oklahoma pregnant women. MCH used this information to make recommendations and facilitate discussion on concerns and changes needed in enhancing the perinatal health care system infrastructure between rural and urban areas as well as primary and tertiary health care providers in the state.

The Healthy Mothers Healthy Babies Coalition, supported with funds from MCH, served as a resource for providers and families about health issues affecting females, pregnant females and infants in relation to health, prenatal care, and specifically prevention of prematurity. A specific area of focus was the prevention and care of late preterm infants.

Support of the Fetal and Infant Mortality Review (FIMR) projects at the Tulsa Health Department (THD) and the Oklahoma City-County Health Department (OCCHD) remained a priority for MCH. Both projects began expansion into the metropolitan statistical areas conducting full case review and community action activities. Medicaid administrative match funds were secured to support

the projects.

The Maternal Mortality Review (MMR), a multi-disciplinary team, met quarterly to review maternal deaths in the state. The meetings were staffed and funded by MCH. Statistically significant trends were not yet identifiable because several years of data were needed due to small numbers of deaths. There were recurring issues noted related to needed hospital staff continuing education with discussions began on how to best approach. MCH also began to explore how MMR could be more formally linked with the FIMR projects in the future, beyond just the FIMR project coordinators being part of the current MMR.

The Perinatal Advisory Task Force (PATF), a collaborative project of the Oklahoma State Department of Health (OSDH) and the Oklahoma Health Care Authority (OHCA), continued to meet every other month. These meetings, co-chaired by the Chief of MCH and the OHCA Director of Child Health, included medical providers, health care agencies and consumers. The PATF began exploring the issue of designated levels of nursery care in an effort to assure infants are delivered at the most appropriate facility. In addition, with the OHCA beginning reimbursement for telemedicine, the PATF engaged in discussions as to next steps to be taken for use of this technology in efforts to enhance appropriateness and quality of care to include delivery at the most appropriate facility for high-risk obstetrical patients.

The Office of Perinatal Continuing Education (OPCE) continued to receive state funding through MCH to provide education and training to medical and nursing staff in rural hospitals. The OPCE provided rural hospital staff with the Perinatal Continuing Education Program (PCEP) to better recognize and manage obstetrical and newborn emergencies. Fifteen hospitals participated fully in the PCEP with eight other hospitals providing PCEP to new staff. Three hundred and ten perinatal health care providers participated in the PCEP, including 22 medical staff members (physicians, certified nurse midwives, physician assistants, and emergency personnel) and 288 nursing staff members (registered nurses, licensed practical nurses, and respiratory therapists).

The Healthy Start projects in Oklahoma and Tulsa counties, the Children First Program, and the Office of Child Abuse Prevention (OCAP) family resource and support projects received technical assistance and support from MCH. These projects and programs provided in-home support to pregnant females and their families to decrease infant morbidity and mortality including education on the signs and symptoms of pregnancy complications and where to seek prompt medical attention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided PRAMS and vital records data through a variety of means to a wide audience to facilitate understanding of the issue			X	
2. Supported the state perinatal coalition, Healthy Mothers Healthy Babies			X	
3. Supported the FIMR projects in Tulsa and Oklahoma City MSAs				X
4. Conducted MMR				X
5. Collaborated with the OHCA to co-chair a task force focused on improving policy for prenatal and neonatal care				X
6. Supported the PCEP to provide continuing education to hospital-based physicians and nurses				X
7. Provided technical assistance to Healthy Start, Children First and OCAP projects				X
8.				

9.				
10.				

b. Current Activities
Support of the FIMR projects at the THD and the OCCHD remains a priority for MCH. Both projects now include beginning expansion into the metropolitan statistical areas and the THD project has began review of fetal deaths.

The MMR completed its first full year of reviews. With input from members and also continuing to look at processes in other states, MCH is refining how the abstraction of cases and reviews are being conducted.

The PATF continues exploring the issue of designated levels of neonatal care in an effort to assure infants are delivered at the most appropriate facility. MCH has had initial discussions with OSDH Leadership about the history of self-designation by Oklahoma hospitals and the need to move to use of the American Academy of Pediatrics (AAP) standards in designation through changes in OSDH hospital regulatory rules.

Two workgroups of the "Preparing for a Lifetime, It's Everyone's Responsibility" statewide infant mortality initiative target efforts to address preconception/interconception health and prematurity in Oklahoma. The Preconception/Interconception Care and Education Workgroup is focusing on educating females with previous poor pregnancy outcomes about the importance of early and appropriate prenatal care and the Prematurity Workgroup is promoting awareness of the magnitude of this issue and interventions to decrease the rate of preterm births and associated morbidity and mortality.

c. Plan for the Coming Year
Support of the FIMR projects' efforts to expand to the metropolitan statistical areas and to include fetal deaths will continue. MMR will be staffed and funded through MCH and will expand to include family interviews. Findings and recommendations from these multidisciplinary review processes will be used to make systems improvements to enhance positive outcomes for mothers and infants.

A toolkit designed specifically for the "Preparing for a Lifetime, It's Everyone's Responsibility" initiative will be used to educate the public on infant mortality and strengthen infant mortality reduction activities at the community level. As part of this statewide infant mortality reduction initiative, the Maternal-Infant Quality Care Collaborative will be implemented seeking voluntary participation of birthing hospitals from across the state to standardize care and education for females with high-risk perinatal conditions to help assure that prenatal care providers provide the same standard of care and education and transfer care as soon as appropriate to assure the best maternal and infant outcomes. In current planning, it is anticipated that MCH will be the single point of contact for the hospitals in assuring their needs are identified and technical assistance provided.

MCH will be informed of funds that may be made available through its application for the First Time Motherhood/New Parents Initiative. If awarded, funds will be used to enhance public awareness of the issues and available support to promote positive maternal and infant outcomes.

Follow-up will occur to move discussions forward with key stakeholders to include the Oklahoma Hospital Association on changes that need to be made to OSDH rules regarding designated levels of neonatal care in hospitals.

MCH will continue to provide support to the Healthy Mothers Healthy Babies Coalition. Technical assistance will continue to the Healthy Start projects in Oklahoma and Tulsa counties, the

Children First Program, and the OCAP family resource and support programs. The Central Oklahoma Healthy Start project will resume weekly radio spots and MCH staff will provide information via these broadcasts about ways to reduce infant mortality including information about the importance of early and appropriate prenatal care to prevent low birth weight and preterm births. A priority focus for interactions will center on identifying ways to address racial disparities seen in infant mortality.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84.8	79.3	80.5	81.7	74.7
Annual Indicator	75.5	74.0	76.4	76.5	76.5
Numerator	39085	39943	41463	41551	41551
Denominator	51775	54010	54281	54290	54290
Data Source				OSDH Vital Records	OSDH Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	77	77.5	78	78.5	79

Notes - 2009
Source: Health Care Information, OSDH. Data for year 2009 are not yet available, hence 2008 data are repeated as a provisional estimate.

Annual performance objectives for 2010-2014 have been revised to reflect current data and continued optimism with the passage of the Health Care Reform Bill in 2009.

Notes - 2008
Source: Health Care Information, OSDH.

Notes - 2007
Source: Health Care Information, OSDH.

Higher future annual performance objectives reflects the expectations of the Soon-To-Be-Sooners Medicaid program which will expand prenatal care available to pregnant women who are non-citizens.

a. Last Year's Accomplishments
In 2008, the most recent year for which Vital Statistics data are currently available, 76.5% of all Oklahoma births occurred to females initiating prenatal care (PNC) during the first trimester of pregnancy. This is a marginal increase from 76.4% reported in 2007. Generally, the rate for receiving first trimester prenatal care among Oklahoma females has been unchanged in recent

years. Data from the Health Care Information, Oklahoma State Department of Health (OSDH) show racial and ethnic variability in receipt of first trimester PNC in 2008: White 78.4%, African American/Black 69.2%, American Indian/Alaska Native 70.4% and Hispanic 67.7%.

April 1, 2009 completed the first full year of Soon-To-Be-Sooners (STBS). STBS provided health care benefits through the State Children's Health Insurance Program for unborn children of pregnant females who would not otherwise qualify for SoonerCare benefits due to their citizenship status.

Support continued for the OHCA on development and implementation of "Online Enrollment" formerly called "No Wrong Door". This project is to establish an online enrollment process allowing members or potential members of SoonerCare to apply and receive eligibility electronically at county health departments and other locations such as local Oklahoma Department of Human Services (DHS) offices and libraries. Once in place, clients would have a Medicaid eligibility determination and, if qualified, a Medicaid identification (ID) number assigned before leaving the location.

September 15-16, 2009, MCH partnered with the Oklahoma Healthy Start projects to provide the Region VI Healthy Start Conference on "Improving Birth Outcomes for our Communities". Several presentations included information on the importance of being healthy before pregnancy and accessing prenatal care early.

As part of the activities of the MCH Comprehensive Program Review conducted with county health departments and routine site visits to contractors, MCH looked at access issues in communities related to prenatal care. Clinic records were audited to assure females with positive pregnancy tests were counseled on the need to initiate care with a maternity health care provider within 15 days. County health departments and contract providers were expected to keep updated resource lists available to assist in linking clients with maternity providers.

County health departments and contract providers served as safety net providers for maternity clinical services. MCH continued to transition from providing full maternity services to being the point of entry for many females (approximately 17,000 per year) for pregnancy testing and linkage with appropriate services depending on the results of the pregnancy test. Most county health departments and contract clinics reported the ability to initiate care for clients within two weeks of the documented positive pregnancy test or request for prenatal services. County health department and contract staff continued to assist with the completion of Medicaid applications to facilitate the approval process.

MCH initiated conversations with the Oklahoma State Department of Health (OSDH) Health Care Information (HCI) on quality improvement activities and training of hospital staff on completion of the birth certificate. Through these conversations, it was verified that there was no consistent approach in hospitals on completion of the birth certificate and no standard definition of what was meant by entry into prenatal care. MCH and HCI identified this as a concern to be explored further so that better quality data might be available on entry into first trimester care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Supported the OHCA on policy and procedure changes with Medicaid				X
2. Partnered with the Oklahoma Healthy Start projects to provide the Region VI Health Start Conference				X
3. Provided technical assistance to county health departments				X

and contract providers to assure appropriate provision of and linkage to prenatal services				
4. Served as a safety net provider for maternity services	X			
5. Began to explore with HCI needed training for hospital staff on completion of the birth certificate				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Preconception/Interconception Care and Education Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility", is conducting focus groups to gain insight into females' attitudes about preventive health care, sources of health information, access to care, and real and perceived barriers to accessing health care for themselves and their children. With African Americans having the highest rate of infant deaths in Oklahoma, this population has been targeted for input through the focus groups. Input is being gathered from females with no children, pregnant females, and females with children under the age of two. The information will be analyzed to identify needed changes to health care services and environments to improve early access and utilization of services and shared with the workgroup leads of the infant mortality initiative for use in their work.

Collaboration continues with the OHCA on "Online Enrollment" with July identified as the latest target date for implementation. Individuals will enter information from any computer and receive an immediate response regarding eligibility. The ability to link with Vital Records data to establish citizenship status is to facilitate the eligibility process. If eligibility is determined, individuals are assigned a Medicaid identification (ID) number at that time facilitating earlier entry into prenatal care services for those physicians requiring a Medicaid number to provide services.

c. Plan for the Coming Year

County health department staff will assist individuals and families to apply for Medicaid benefits through the online enrollment process. This process will assist females who are pregnant to achieve earlier access to prenatal care as eligibility will be determined more quickly and they will possess a Medicaid ID number for use in setting up appointments with providers. It is anticipated that the pilot project in eight county health departments that have a staff person responsible for assisting individuals and families with this process will be expanded. Medicaid administrative match funds will be provided by the OHCA to support these positions.

County health departments will continue to provide maternity clinical services as a safety net provider. County health departments and contract providers no longer having maternity clinics will still provide pregnancy testing and will keep updated resource lists available to assist in linking clients with maternity providers.

The web pages for "Preparing for a Lifetime, It's Everyone's Responsibility" will continue to be updated with information regarding the importance of preconception care and early entry into prenatal care as a method of impacting infant mortality in the state. The web pages will also include updated information on resources including how and where to apply for SoonerCare and STBS. Resource cards identifying practices to promote a healthy pregnancy to include entry into prenatal care during the first 12 weeks as well as a multitude of resources have been developed as part of the initiative on infant mortality. These cards, that fold over and are the size of a business card for ease of carrying, will be promoted with health care providers and pharmacies as a resource for pregnant females.

MCH will continue Comprehensive Program Review visits to county health departments and routine site visits to contractors and assess access issues in communities related to prenatal care, especially in communities where MCH funded maternity clinics have closed. Guidance will be provided to health care providers on strategies to educate women on the importance of receiving early prenatal care. Clinic records will continue to be audited to assure women with positive pregnancy tests are counseled on the need to initiate prenatal care within 15 days and linked with needed resources.

MCH, HCI and the Oklahoma Hospital Association will identify plans to provide training to hospital staff so that the quality of data received for entry into prenatal care is improved. A standard definition of what entry into prenatal care means will be developed for use in the training.

MCH will also work with the Oklahoma Hospital Association on education and training of emergency room health care providers to enhance their understanding of the need for early care and linkage with services.

D. State Performance Measures

State Performance Measure 1: *The percent of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40.9	50.8	49.8	48	47.8
Annual Indicator	48.8	48.4	48.0	50.3	50.3
Numerator	25266	24950	25073	26233	26233
Denominator	51775	51545	52250	52200	52200
Data Source				Oklahoma PRAMS	Oklahoma PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	47.6	47.4	47.2	47	

Notes - 2009
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2008. Data for year 2009 are not available at this time, hence 2008 data used as provisional estimate.

Notes - 2008
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2008.

95% CI: (46.6%, 53.9%)

Notes - 2007
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2007.

Despite having exceeded the Annual Performance Objective for 2006, the objectives for 2008-2012 have not been revised for lack of evidence of a significant decrease in the percent of pregnancies which are unintended.

a. Last Year's Accomplishments

MCH continued to monitor unintended pregnancy through data from the Centers for Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system that provides health information on women who delivered a live birth in Oklahoma. In 2008, the latest PRAMS data available, approximately 50.3% of Oklahoma live births were the result of an unintended pregnancy, with 39.7% mistimed and 10.6% unwanted. This finding is consistent with previous years reporting of the PRAMS data, which has seen the unintended pregnancy rate among live births fluctuate slightly from year-to-year but remain at nearly half of all live births.

The Oklahoma Medicaid Family Planning Waiver (SoonerPlan), implemented April 1, 2005, continued to provide family planning services to uninsured females and males 19 years of age or older who were United States citizens or qualified aliens, residents of Oklahoma, not eligible for regular Medicaid, and who met the income standard (185% of Federal Poverty Level). Services provided included office visits and physical exams related to family planning; birth control information, methods and supplies; laboratory tests including pap smears and screening for sexually transmitted diseases (STDs); pregnancy tests; tubal ligations for females age 21 and older; and, vasectomies for males age 21 and older. The Oklahoma State Department of Health (OSDH) continued to collaborate with the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) to evaluate and improve services provided through SoonerPlan. Oklahoma submitted a request to the Centers for Medicare and Medicaid Services (CMS) for renewal of the waiver for an additional 3 years. The renewal request proposed adding the contraceptive option Implanon as an additional long-term option for birth control.

Family planning services were provided through county health departments and contract clinics. Services included medical histories, physical exams, laboratory services, methods education and counseling, provision of contraceptive methods, STD/human immunodeficiency virus (HIV) screening and prevention education, pregnancy testing, immunizations, and education on smoking cessation, nutrition, and exercise. Services were provided to a total of 70,877 females and males of reproductive age for calendar year 2009.

The OSDH Commissioner's Action Team on Reduction of Infant Mortality expanded to engage partners at the state, regional, and community levels in a statewide effort to impact infant mortality. Press releases and interviews on "Preparing for a Lifetime, It's Everyone's Responsibility", stressed the importance of viewing every interaction with a health professional as an opportunity to address preconception and interconception health issues to decrease unintended pregnancies and improve infant outcomes. MCH also launched a website (http://iio.health.ok.gov) with information on many topics felt to impact infant mortality including preconception/interconception health, contraception, and healthy pregnancy spacing.

Staff development opportunities were provided throughout the year based on the MCH annual staff development training needs assessment conducted each spring as well as federal Title V and Title X priorities and key issues.

MCH received supplemental funds and grant funds from federal Title X Family Planning to target racial disparities in Oklahoma and Tulsa counties' African American population. Family planning services were resumed in a predominantly African American neighborhood in Oklahoma City and expanded to high-risk zip codes in Tulsa. Outreach workers targeted low income, at-risk, and uninsured males and females of reproductive age. Six hundred seventy clients were seen at these sites for family planning services to help prevent unintended pregnancy.

See NPM # 8.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinated with the OHCA and OKDHS to assure effective and efficient provision of Medicaid family planning waiver services				X
2. Provided clinical family planning services through county health departments and contract providers	X			
3. Used media opportunities to educate the public on the importance of preconception and interconception care			X	
4. Launched website that included information on preconception/interconception health, contraception, and healthy pregnancy spacing			X	
5. Provided staff development (training) opportunities				X
6. Received federal Title X supplemental funds to support special projects in Oklahoma and Tulsa counties focused on access to services for the African American population	X			
7.				
8.				
9.				
10.				

b. Current Activities

Family planning services continue to be provided in predominantly African American neighborhoods in Oklahoma City and Tulsa. Both are looking to expand services. In Oklahoma City, outreach workers will partner with the OSDH Office of Minority Health through the Community Baby Showers and the Fatherhood Initiative to promote family planning and pregnancy intention.

SoonerPlan completed its fifth year April 1. Interim ongoing approvals from CMS are being received while the renewal request continues to be reviewed. Enrollment is increasing each month with April 2010 enrollment at 24,486 compared to 17,651 in April 2009.

The Preconception/Interconception Care and Education Workgroup of the infant mortality initiative is conducting focus groups to assess females' attitudes and knowledge about health, health care, and access to health care; prevention of unintended pregnancies; and sources of education regarding health care issues. This information will be used for changes in policy and services. In addition, the newly developed Preconception/Interconception Health Assessment Tool is being finalized for piloting in health department clinics with females and males waiting to be seen for their family planning appointment. A nurse will review results of the self-assessment with the client.

See NPM #8.

c. Plan for the Coming Year

PRAMS data and data from linkage of PRAMS, vital records, and Medicaid will be used to inform stakeholders and policymakers. Information learned from the focus groups conducted by the Preconception/Interconception Care and Education Workgroup will be shared with other workgroups of the infant mortality initiative as well as stakeholders for use in their work to improve policy and services related to unintended pregnancy.

It is anticipated that Oklahoma will receive a three-year approval from CMS to continue providing family planning services through SoonerPlan to low-income females and males of reproductive age who would otherwise not be eligible for Medicaid covered services. If approved by CMS,

Implanon, treatment for STDs, and the Guardasil vaccine will be provided through the waiver. MCH will continue working with the OHCA on the possibility of covering preconception education under the waiver as a part of physical examinations and as an individual counseling service.

Family planning services will be provided through county health departments and contract clinics. Services will include medical histories, physical exams, laboratory services, methods education and counseling, provision of methods, STD/HIV screening and prevention education, pregnancy testing, immunizations, and education on smoking cessation, nutrition, exercise, and healthy weight.

The federally funded Title X Family Planning special projects focused on outreach, education, and provision of family planning clinical services to the African American population will move into its third year in Oklahoma and Tulsa counties. These special projects are supported as a priority from the Region VI Title X Family Planning Office given Oklahoma's rate of unintended pregnancy in the African American population and disparities in infant mortality between the white and African American populations.

The Preconception/Interconception Care and Education Workgroup will complete the pilot of the Preconception/Interconception Health Assessment and Education Tool in county health departments and revise the tool as indicated for use statewide with public and private providers.

Social media options will be explored to promote family planning services and education to all females and males of reproductive age who choose to participate. Messages about pregnancy prevention will be included in social marketing.

Numerous staff development opportunities will be provided throughout the year with topics to include unintended pregnancy, adolescent pregnancy prevention, the relationship of drug and alcohol abuse in adolescents to unintended pregnancy, and creative methods for including males in clinic services.

See NPM #8.

State Performance Measure 3: *The percent of adolescents grades 9-12 smoking tobacco products*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	24.4	28.2	27.7	23	22.7
Annual Indicator	28.6	28.6	23.2	23.2	22.6
Numerator	42781	42970	35197	41369	39886
Denominator	149585	150246	151710	178316	176488
Data Source				YRBS	YRBS
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	22.4	22.1	21.8	21.5	

Notes - 2009
Source: Numerator derived from 2009 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2008-2009 season.

95% CI: (20.2%, 30.4%)

Notes - 2008
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2007-2008 season.

Notes - 2007
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

a. Last Year's Accomplishments
The Youth Risk Behavior Survey (YRBS) was completed in May 2009 with 41 of 49 schools participating in the survey. Participation rates were such that Oklahoma received weighted data for the fourth straight survey. Efforts were coordinated between the Oklahoma State Department of Health (OSDH) Tobacco Use Prevention Service, Cherokee Nation, and Oklahoma State Department of Education (OSDE) for the administration of the YRBS, the Youth Tobacco Survey (YTS), and an independent YRBS survey being completed by the Cherokee Nation.

Data from the statewide 2009 Oklahoma YRBS revealed that 25.3% of adolescents reported smoking any tobacco products, and 22.6% of adolescents in grades 9-12 reported cigarette smoking in the past 30 days, which is the time period used to define a current smoker. This finding was a very slight decrease in the smoking rate of 23.2 % in 2007, although the change was not statistically significant. According to national 2007 YRBS data from the Centers for Disease Control and Prevention (CDC), an estimated 20% of high school students were current cigarette smokers.

Similar to the YRBS, the YTS data showed the percentage of students who had ever tried smoking declined from 54.5% in 2007 to 52.9% in 2007. The percentage of students who smoked a whole cigarette for the first time before age 13 also decreased significantly from 15.9% in 2007 to 11.1% in 2009.

The Oklahoma Health Improvement Plan (OHIP) was in final draft and outlined numerous key priorities and outcomes to support health improvement throughout the state. Senate Joint Resolution (SJR) 41, passed by the Oklahoma Legislature in 2008, directed the State Board of Health to prepare a report that outlined a plan for the "general improvement of the physical, social and mental well being of all people in Oklahoma through a high-functioning public health system." The OHIP addressed improving health outcomes through three targeted "flagship initiatives": tobacco use prevention; obesity reduction; and children's health. For tobacco use prevention, the OHIP goals aligned with the cessation, prevention, and protection measures already outlined in the Oklahoma State Plan for Tobacco Use Prevention and Cessation of which one goal is to "prevent initiation of tobacco use by youth and young adults."

State dollars continued to fund 13 rural district school health nurses through a contractual agreement with the OSDE. Tobacco use prevention was a priority within each school health nurse's annual work plan. The School Health Coordinator in MCH provided technical support and assistance to all school nurses statewide.

Collaboration continued with the Tobacco Use Prevention Service and OSDH Dental Health Service promoting prevention activities and efforts across the state. Strategies to reduce tobacco use included support for comprehensive community-based tobacco prevention initiatives. A specific example of a major activity of these local initiatives was work accomplished with schools in the state to develop and adopt policy that would not allow tobacco use on school grounds 24-hours a day seven days a week.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Administered the 2009 YRBS				X
2. Provided for school health nurses in 13 rural school districts; tobacco cessation was a focus area			X	
3. Collaborated with the OSDH Tobacco Use Prevention Service and Dental Health Service on youth prevention activities and efforts across the state			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH has received the 2009 YRBS data and is developing fact sheets containing the current and previous data. The data are separated by topic into eight fact sheets with plans to have fact sheets finalized for distribution this summer. The fact sheets will be placed on the OSDH website for public viewing and access. With placement of the fact sheets on the agency website, local county health department staff (e.g., health educators, social workers, child guidance clinicians) and other interested parties will have immediate access and the ability to copy and use the fact sheets.

MCH continues to provide technical support and resources to the state funded school nurses in rural Oklahoma. The school nurses provide one-on-one, in-class, and group education on tobacco prevention and cessation. MCH provides technical assistance for the development of the school nurses' annual plans, which outline specific goals, objectives, and activities to be completed within the school year. Each annual plan submitted by the nurses includes a component addressing tobacco use prevention and cessation.

c. Plan for the Coming Year

MCH will continue to seek opportunities to present YRBS data and information on the background and benefits of participating in the statewide survey to education leadership groups, public health entities, and parent organizations, such as the Parent Teacher Association (PTA). Revisions to the YRBS protocol will be completed and approved by the CDC and OSDH Institutional Review Boards (IRBs). The YRBS will be administered in the late winter/early spring of the 2010-2011 school year.

A contractual agreement with the OSDE to fund school nurses in rural areas of Oklahoma will continue. MCH will work directly with these school nurses to provide technical assistance and support for the development of annual work plans which include goals and objectives related to tobacco use prevention and tobacco use cessation programs at all grade levels.

MCH will continue to follow tobacco-related legislation, as it is introduced, to reduce youth access to tobacco products or exposure to second hand smoke.

MCH will support the Tobacco Use Prevention Service in the development of a fact sheet to be used as a resource to help raise awareness of the highly-sophisticated tobacco industry marketing efforts being facilitated by the use of the digital technology embedded in Oklahoma driver's licenses. The Oklahoma State Plan for Tobacco Use Prevention and Cessation and the OHIP emphasize the need to prohibit the use of any electronically scanned information from

driver's licenses for the marketing of tobacco products.

MCH will coordinate with the Tobacco Use Prevention Service on strategically planned and executed meetings with key community leaders and local government to advocate for local youth access ordinances and educate about youth access.

MCH will support the Tobacco Use Prevention Service with implementation of researched based curricula in school districts in the 24 Communities of Excellence service areas across the state. To be eligible to receive curricula, the school district must have a 24/7 No Tobacco Use School Policy and commit to the fidelity of the model. Additionally, support will be provided on monitoring product sampling and driver license scanning by the tobacco industry at local rodeos, festivals, and state fairs that allow tobacco sponsorship and/or sampling.

State Performance Measure 4: *The number of families with a child with special health care needs receiving respite care provided through the CSHCN program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	134	144	160	168	60
Annual Indicator	142	152	138	62	67
Numerator					
Denominator					
Data Source				CSHCN Program, OK Dept of Human Services	CSHCN Program, OK Dept of Human Services
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	60	60	

Notes - 2009
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

Notes - 2008
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

Number of respite vouchers provided by CSHCN has decreased because of the availability of funding from other sources. This is an unduplicated count, however CSHCN provides 2 vouchers per year to most families.

Notes - 2007
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

a. Last Year's Accomplishments
The Oklahoma Areawide Services Information System (OASIS) remained the central processing agency for respite care applications in the state. The OASIS determined eligibility and made

referrals to the appropriate funding sources: CSHCN, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division or the OKDHS Children and Family Services Division which administers programs for children in foster care. The OASIS received 2,272 first time requests for applications to the Respite Voucher Program. The OASIS determined each family's eligibility then routed the application to the proper funding source. CSHCN issued vouchers for 67 families, the Developmental Disabilities Services Division issued 121 vouchers, and the Children and Family Services Division issued 32 vouchers. All three sources issued approximately the same number of vouchers as the year before.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided for respite services		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oklahoma Respite Resource Network (ORRN) is one of over a hundred organizations that make up the ARCH (Access to Respite Care and Help) National Respite Coalition's Lifespan Respite Task Force. The purpose of the task force is to make quality respite care universally accessible and assure caregivers are given the tools they need to find and train respite service providers when they are needed. Part of the effort involves helping caregivers understand that there is nothing wrong with needing a break from tending to their loved one's needs.

The ORRN, along with the rest of the Task Force, is working for the renewal of the Lifespan Respite Care Act (PL 109-442). President George W. Bush signed the Lifespan Respite Care Act into law in 2006. It provides for competitive bid grants for states to create and maintain respite care networks. President Obama's proposed budget increases funding for respite care, but emphasizes respite for those caring for the elderly. The ORRN is advocating to help the President and Congress understand that the caregivers for children with special health care needs also need assistance with respite care.

c. Plan for the Coming Year

The ORRN will update the Respite Provider Registry as providers stop services and others begin. CSHCN will continue working with the ORRN to identify additional sources of funding to expand the respite services. The OASIS will remain as the administrator of the respite programs for the divisions at OKDHS that provide respite services (CSHCN, the Developmental Disabilities Services Division, and the Children and Family Services Division).

The OASIS will make respite information available via Facebook. This will increase awareness and improve communication with those who may need respite services. The OASIS and the ORRN are also developing training materials. There will be separate materials for families and providers that explain exactly what respite is. In Oklahoma, the agencies that provide respite

services send vouchers to families to pay the respite provider of their choice. The family training material will explain who they can use as a paid respite provider as well as other responsibilities the family will have. The provider training material will explain what the provider's responsibilities are while giving care, how the voucher must be filled out to get paid, and how long it may take to get paid.

Sibshops, sponsored by the Child Study Center at the University of Oklahoma Health Sciences Center, will continue operating in various communities around the state. Sibshops are designed for the brothers and sisters of children with special needs. Depending on the needs and available resources in each community, Sibshops are held weekly, monthly or, in the case of all day events, annually. Sibshops are not designed with therapy in mind, but are designed to be fun times that celebrate siblings and what they do for their brothers and sisters with special needs. Facilitators do make recommendations for therapy or extra help for children they notice may need assistance. A variety of activities occur at these events such as art, cooking, sports, special guests, and music.

State Performance Measure 6: *The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		21	21	18	18
Annual Indicator	14	14	15	15	16
Numerator					
Denominator					
Data Source				MCH Assessment, OSDH	MCH Assessment, OSDH
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	18	18	18	18	

Notes - 2009
Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

Notes - 2008
Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

Notes - 2007
Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A. Future annual performance objectives have been adjusted to more realistically reflect MCH data capacity.

a. Last Year's Accomplishments
Linkage between the Oklahoma State Department of Health (OSDH) vital records and the Medicaid eligibility and paid claims was achieved and facilitated with a position jointly funded by both the OSDH and the Oklahoma Health Care Authority (OHCA), the state Medicaid agency. The analyst in this position focused on the electronic linkages of agency databases and verifying the accuracy of those linkages. The State Systems Development Initiative (SSDI) Coordinator

worked with the OSDH/OHCA position to review and analyze linked data.

A workgroup comprised of OSDH and OHCA staff was created to review data and requests for data in the linked databases. The workgroup met monthly and reviewed tables and charts created from the linked databases. The information from this workgroup was used to investigate demographic and perinatal health disparities in the populations of females whose deliveries were covered either by private insurance or Medicaid (SoonerCare and Soon-To-Be Sooners).

Birth and infant death certificates were routinely linked within the OSDH Office of Vital Records. The past four years have seen a significant improvement in the completeness of these matched records, which resulted in a match rate of over 98% each year. Beginning with April 2009 births, Oklahoma began utilizing the 2003 Revision of the Birth Certificate. This caused minor delays for projects like the Pregnancy Risk Assessment Monitoring System (PRAMS) that rely on birth certificate data to create a sample, due to necessary changes in sampling programs.

Linkage was also completed using OSDH Immunization data and Medicaid data.

The PRAMS continued to operate within MCH. This permitted analyses on demand with a number of PRAMSGRAMs produced. These included African American perinatal health disparities, prenatal care content disparities, and stressors and social supports during pregnancy. In addition to prepared reports and presentations, data from PRAMS were utilized by multiple groups within the OSDH as well as external partners. Uses included building awareness, documentation of need, support for grant applications, and general information. PRAMS data were linked to Medicaid to validate the PRAMS questions on Medicaid participation.

Oklahoma continued to maintain one of the more comprehensive active birth defects surveillance systems in the country. The primary complication continued to be access to this confidential dataset.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Linked databases for monitoring the health status of MCH population groups				X
2. Maintained one of the more comprehensive active birth defects surveillance systems in the country				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data used to assess this measure are derived from the reporting on Health Systems Capacity Indicator (HSCI) #09A. State data capacity defined under HSCI #09A is the principal focus of the SSDI Grant defined by Oklahoma to expand its ability to gather and analyze data important to assessing the maternal and child health population.

Direct annual data linkages include those targeted (listed on Form 19) for births/infant deaths; births, Medicaid, and the Women, Infants and Children Nutrition Program (WIC); and, births to

newborn screening data. Linkages between live births and infant deaths are now being performed annually by the OSDH Center for Health Statistics, Office of Vital Records, while linkages between births and the other databases are under development.

Work has begun to link Immunization data and The Oklahoma Toddler Survey (TOTS) data to identify gaps and disparities in coverage.

PRAMS continues to operate efficiently and is committed to producing routine publications of topics considered important to the MCH public audience and field of practice.

The SSDI Coordinator resigned in December 2009. The duties of the position have been assumed by the Director of MCH Assessment.

The Medicaid Matching Analyst resigned in January 2010 with the position approved for refill. The search for a new analyst is underway.

c. Plan for the Coming Year

Efforts are underway to make more of the data available to providers and the general public. Outlets for the use of linked data will be maintained and expanded to enhance the awareness of the health status and need of the MCH population groups.

MCH will work on a data sharing agreement to link PRAMS and TOTS to hospital discharge data to explore re-hospitalization among infants born prior to 37 weeks gestation.

MCH Assessment and the OSDH Immunization Service will continue to develop analysis plans to link PRAMS and TOTS survey data with Oklahoma State Immunization Information System (OSIIS) data in order to improve vaccine coverage rates at 24 months of age. An annual report will be developed to help identify barriers, gauge progress, and discover disparities in vaccinations. Annual linkage of OSIIS data with Medicaid data will continue.

Future steps for data linkage will include linking matched Medicaid data to the Public Health Oklahoma Client Information System (PHOCIS), the OSDH's database that includes clients served in Maternity, Child Health, Family Planning, WIC, and Children First, the nurse-family partnership program for the state.

Analyses of the Medicaid linked data will restart with the potential to link Medicaid (SoonerCare, Soon-To-Be-Sooners and SoonerPlan) data to PRAMS, TOTS and other data sources within OSDH.

A memorandum of intra-agency coordination will be formalized to gain access to OBDR data.

The joint OHCA/OSDH Perinatal Advisory Task Force and Child Health Advisory Task Force will be utilized to provide input into detailed analyses of the linked data as it is being developed by MCH. The advisory groups are composed of individuals representing academia, professional organizations, providers, advocates, and families. The task forces explore issues surrounding the delivery of health services with a particular focus on Medicaid, including barriers, scope, and other concerns. Because Medicaid covers more than 50% of all deliveries in Oklahoma, their interests are very useful in providing an external perspective for analyzing these large databases.

State Performance Measure 7: *The percent of children with special health care needs who are Medicaid eligible and report receiving routine dental care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		20	39.4	42	42.5
Annual Indicator		38.3	41.5	43.8	45.5
Numerator		10908	10758	10110	10112
Denominator		28496	25921	23073	22246
Data Source				CSHCN program	CSHCN program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	43	43.5	44	44.5	

Notes - 2009
Source: CSHCN program, OKDHS.

Notes - 2008
Source: CSHCN program, OKDHS.

Notes - 2007
Source: CSHCN program, OKDHS. Medicaid claims data, OHCA.

a. Last Year's Accomplishments
The Oklahoma Health Care Authority (OHCA) reported an average of 10,112 monthly encounters for routine dental services for Medicaid-eligible children who were classified as disabled or who were in the custody of the state. This was approximately the same number of encounters as reported last year.

The Children's Oral Health Coalition (COHC) continued to work on the 2010 Mission of Mercy (MOM) anticipating at least 2,000 individuals to seek services, many of those children. The two-day event was scheduled for Tulsa in February 2010. Volunteers were signed up to cover the four day event from setting up, providing of services, and clean-up of the site.

Oklahoma's Governor, Brad Henry, issued a proclamation supporting the Oklahoma Head Start Dental Home Initiative, part of a national campaign by the American Association of Pediatric Dentistry. Teams were organized to begin working around the state.

The Governor's Task Force on Children and Oral Health continued to meet to finalize their report. The task force was made up of professionals and family members and co-chaired by a dentist and parent of an adult child with special needs. During the March meeting, it was decided to send a recommendation to the Department of Environmental Quality that some of the stimulus money going to states for water quality programs be earmarked to fluoridate water in rural Oklahoma. The final report was released in August. Included in the report's recommendations were making dental sealants and fluoride varnish available to young children; educating all Oklahomans so they understand dental decay is an infectious and transmittable disease; insuring that adequate programs and workforce are in place so everyone has access to oral health care, especially those with physical, mental, and developmental disabilities; establishing comprehensive oral health care in the American Indian population; and, educating oral health care providers on dealing with the challenges that come with certain children with special needs. Each recommendation was given with a possible timetable and plan for achieving it.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated with the Children's Oral Health Coalition in planning of the Mission of Mercy				X
2. Participated on the Governor's Task Force on Children and Oral Health				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The first Oklahoma MOM was a great success. Held in Tulsa in February, approximately 2,000 adults and children were served at the two-day event. Professionals performed teeth cleaning, tooth extractions, fillings, and root canals. Planning started for the 2011 MOM to be held in Oklahoma City.

The AAPD (American Academy of Pediatric Dentists) and Head Start are partnering at the national, regional, state, and local levels to develop a national network of dentists to link children in Head Start with dental homes. Oklahoma began participating last year. In Oklahoma, the Head Start Association, the American Indian Head Start Director's Association, and other partners have developed workgroups and advisory boards to develop and execute the initiative. Head Start and Early Head Start staff have been trained in presenting the importance of good dental hygiene to both children and their parents. Five thousand copies of the pocket version of the booklet "Oral Health Care for Children with Special Health Care Needs" have been distributed.

Federal grant funds are being used to develop an infrastructure so that the partnerships between provider networks and Head Starts can be sustained. The funding is also being used to integrate oral health education into the continuing medical education (CME) of pediatricians, family physicians, and pediatric nurses to increase awareness of the importance of oral health to a patient's overall health and welfare.

c. Plan for the Coming Year

This state performance measure has been discontinued. Information from the Five Year Needs Assessment documented a need to focus on access to specialized dental care for CSHCN versus routine dental care. A new state performance measure has been developed.

State Performance Measure 8: *The percent of adolescents grades 9-12 not using alcohol during the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		60.7	61.9	63.1	64.4
Annual Indicator	59.5	59.5	56.9	56.9	61.0

Numerator	89003	89396	86323	101462	107709
Denominator	149585	150246	151710	178316	176488
Data Source				YRBS & OK State Dept of Education	YRBS & OK State Dept of Education
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65.7	66.4	67.1	67.8	

Notes - 2009
Source: Numerator derived from 2009 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2008-2009 season.

95% CI: (57.0%, 65.1%)

Notes - 2008
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2007-2008 season.

Notes - 2007
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

a. Last Year's Accomplishments
The Oklahoma Youth Risk Behavior Survey (YRBS) collects data from students in grades 9-12 to track this measure. Data from the 2009 YRBS showed that 39.0% of Oklahoma adolescents had used alcohol in the 30 days prior to the administration of the survey. No significant differences were observed by gender as 39.6% of female adolescents reported alcohol use during the last 30 days compared to 38.2% of males. The most recent national data, 2007, shows 55.3% of students grades 9-12 reported no alcohol use in the previous 30 days.

The percentage of students in Oklahoma who had their first drink of alcohol (other than a few sips) before thirteen years of age has decreased significantly from 26.8% in 2003 to 19.4% in 2009. Females had a significantly lower percentage than males at 15.3% and 23.6%, respectively. The percentage of students who had five or more drinks of alcohol in a row (within a couple of hours) one or more times in the past 30 days decreased significantly from 34.0% in 2003 to 24.0% in 2009.

The MCH Adolescent Health Coordinator and staff from the Oklahoma State Department of Health (OSDH) Injury Prevention Service, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), and Oklahoma Highway Safety Office began more formal planning to develop strategies to prevent and reduce underage drinking. Quarterly meetings between MCH and Injury Prevention Service assisted in the development and implementation of these activities.

The Adolescent Health Coordinator continued to serve on the Governor's Task Force on Prevention of Underage Drinking. Oklahoma was one of a select number of states chosen by the Substance Abuse and Mental Health Services Administration (SAMHSA) to create a video with a prevention focus to be completed by Spring 2009. Funding and technical expertise for creation of the video was provided by SAMHSA. The Adolescent Health Coordinator also participated in the ODMHSAS sponsored alcohol compliance checks across Oklahoma City and presented information to state agency staff and at conferences focusing on adolescent brain development and the damaging effects of alcohol on the developing brain.

Since Governor Henry signed The Prevention of Youth Access to Alcohol Bill on May 25, 2006,

social host ordinances have passed in 78 communities across Oklahoma. With help from grassroots efforts such as Turning Point, city officials gained understanding and knowledge of how this ordinance can assist with preventing underage drinking parties by holding the "host" of the party liable for allowing underage drinking to occur on their property.

The Oklahoma Institute for Child Advocacy (OICA) Fall Forum was held in October 2008. A legislative request was made to appropriately classify flavored alcoholic beverages (Alco-Pops) as distilled beverages, as currently defined in Oklahoma law, thereby requiring such beverages to be sold only in liquor stores. This change would increase the tax on these products and prevent them from being sold in certain areas such as convenience or grocery stores, which would have great impact on the accessibility to youth.

The Oklahoma Highway Safety Office transferred the 2M2L (Too Much to Lose) underage drinking prevention program to the ODMHSAS. MCH met with the ODMHSAS to begin discussions on how MCH might collaborate and support 2M2L.

In January, MCH received the final report of Oklahoma's Adolescent Health System Capacity Assessment, a process designed to support improvement in the state's infrastructure to achieve critical objectives and public health quality for adolescents. As a result of this process, participants prioritized adolescent key health issues that were to be developed into a conceptual framework and state plan for adolescent health.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partnered with the OSDH Injury Prevention Service, ODMHSAS, and Oklahoma Highway Safety Office for the development of strategies to reduce adolescent alcohol use				X
2. Participated in the Governor's Task Force on Prevention of Underage Drinking				X
3. Monitored the impact of state policy on youth access to alcohol; provided education and served as resource to stakeholders on proposed legislation				X
4. Began use of the final report of Oklahoma's Adolescent System Capacity Assessment in state planning efforts				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH is updating the Alcohol Use YRBS Fact Sheet to include the 2009 YRBS data. The fact sheet will be shared with school leaders, county health departments, local and statewide media outlets, legislators, community coalitions, and other state partners who invest resources aimed at reducing underage drinking.

The Adolescent Health Coordinator continues to provide representation on the Governor's Task Force on Underage Drinking. The task force continues to promote legislation directed toward decreasing alcohol accessibility to underage youth and provide consistent information and educational resources related to underage drinking and the negative health outcomes to

programs that provide services with adolescent focused components.

The Adolescent Health Coordinator is currently providing expertise on the different life stages of adolescence, brain development and maturation, and the link to risk taking behaviors, including substance use and abuse. These presentations have been given to school districts, youth ministers, and various agencies and entities which serve the youth population.

c. Plan for the Coming Year
This state performance measure has been discontinued. This issue was not identified as a priority focus for 2011-2015 in the Five Year Needs Assessment process. MCH will continue to be involved in activities with the Governor's Task Force and Injury Prevention Service. MCH will monitor trends through YRBS to ensure continued positive impact on this issue with its relationship to adolescent pregnancy and motor vehicle injury.

State Performance Measure 10: *The percent of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective				29.6	29.3
Annual Indicator	31.1	31.1	29.9	29.9	30.6
Numerator	46521	46727	45361	53316	53978
Denominator	149585	150246	151710	178316	176488
Data Source				YRBS & OK State Department of Education	YRBS & OK State Department of Education
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29	28.7	28.4	28.1	

Notes - 2009
Source: Numerator derived from 2009 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2008-2009 season.

95% CI: (27.5%, 33.7%)

Notes - 2008
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is high school enrollment during 2007-2008 season.

Notes - 2007
Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

a. Last Year's Accomplishments
According to the latest Youth Risk Behavior Survey (YRBS) data there have been no significant changes in the percent of adolescents who were overweight or obese in the past 4 years. In

2009, 30.6% of adolescents in grades 9-12 were overweight or obese compared to approximately 29.9% in 2007. In 2009, no significant differences were observed between females and males for the prevalence of overweight or obese at 30.1 and 31.1%, respectively.

MCH continued to provide input on nutrition and physical activity for children and adolescents to the Governor's Call To Action Team through the Oklahoma State Department of Health (OSDH) Commissioner's Call To Action Team on Nutrition and Physical Activity. The Commissioner's Action Team continued to meet providing support to activities that promote health and physical education to students in all grades. For the Coordinated Approach to Child Health Program (CATCH), the School Health Coordinator in MCH assumed a leadership role and assured coordinated efforts between the in-school and after-school CATCH. Staff meetings were held monthly to provide updates across program services to assure continuity of service delivery and eliminate duplication of effort.

Financial and technical assistance continued to be provided to the Schools for Healthy Lifestyles (SHL) Program. The program included 52 schools in 11 counties including the metropolitan area. SHL continued to focus on nutrition and physical activity for two of the four components of the program. MCH also continued to provide financial and technical assistance to the Tulsa Health Department's It's All About Kids (IAK) Program. This program followed the Centers for Disease Control and Prevention (CDC) Coordinated School Health Program Model and along with community collaboration provided the only coordinated school health program model in Oklahoma. Sixteen schools in the Tulsa County area participated in this program.

MCH began development of a Request for Proposal (RFP) to meet the legislative requirement outlined in Senate Bill (SB) 519, which directed the OSDH to develop a fitness assessment software program for elementary age school children to track various measurements of student fitness including body mass index (BMI), aerobic endurance, strength, and flexibility. SB 519 provided that the program shall have the capability of creating confidential reports for parents that include explanations of the data and suggestions for appropriate actions.

The Oklahoma Health Improvement Plan (OHIP) was in final draft and outlined numerous key priorities and outcomes to support health improvement throughout the state. Senate Joint Resolution (SJR) 41, passed by the Oklahoma Legislature in 2008, directed the State Board of Health to prepare a report that outlined a plan for the "general improvement of the physical, social and mental well being of all people in Oklahoma through a high-functioning public health system." The OHIP addressed improving health outcomes through three targeted "flagship initiatives": tobacco use prevention; obesity reduction; and, children's health. For obesity reduction, the OHIP aligned with strategies and public policy recommendations in the already developed Get Fit Eat Smart Oklahoma Physical Activity and Nutrition Plan.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided input to the Governor’s Call To Action Team				X
2. Participated on the OSDH Commissioner’s Call To Action Team on Nutrition and Physical Activity				X
3. Assured coordinated efforts between the in-school and after-school CATCH				X
4. Supported nutrition and physical activity services through the Schools for Healthy Lifestyles and It’s All About Kids programs			X	
5. Began development of RFP to acquire fitness assessment software				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
MCH has received the 2009 YRBS data and is developing fact sheets containing the current and previous data. The data are separated by topic into eight fact sheets (one being Obesity) with plans to have fact sheets finalized for distribution this summer. The fact sheets will be placed on the OSDH website for public viewing and access. With placement of the fact sheets on the agency website, local county health department staff (e.g., health educators, social workers, child guidance clinicians) and other interested parties will have immediate access and the ability to copy and use the fact sheets.

Final steps were accomplished to make the purchase of an online fitness testing data utility tool in February 2010. Export files from five pre-identified schools were used to test the transfer of data from the local school level to the utility maintained by the OSDH. Additional testing included usability of data once received by the agency. Training of staff in the use of the fitness testing software and utility occurred June 23-24 in preparation for conducting a pilot in the coming school year.

The OSDH received $250,000 of American Recovery and Reinvestment Act of 2009 (ARRA) funds from the Governor's Office in March 2009 in support of expanding SHL. MCH is working with SHL on an expansion plan.

c. Plan for the Coming Year
MCH will begin working with the Oklahoma State Department of Education and other identified stakeholders to coordinate efforts for administration of the 2011 YRBS. The YRBS Specialist will be available for presentations related to current data and trends. YRBS fact sheets will be sent to school administrators, legislators, and others interested in policy development around obesity prevention.

Support will continue for in-school and afterschool CATCH. MCH will continue to partner with the SHL and IAK programs to support nutrition and physical activity education and evaluation in their respective school sites. Planning will also take place with Oklahoma City-County Health Department as activities are initiated in select high-risk schools in the county.

Partnerships will continue with OSDH Chronic Disease Service, Fit Kids Coalition (FKC) and Action for Healthy Oklahoma Kids (AHOK) to provide training to school staff on conducting the School Health Index. MCH will continue to work with schools to adopt the CDC Coordinated School Health Program model.

The fitness testing software pilot will be completed and planning initiated for expansion to new schools during the 2011-2012 school year. MCH will further test the utility's capability of receiving the data from individual schools and producing reports at the school, district, regional, and state levels.

State Performance Measure 11: *The percentage of full-term infants who are put to sleep on their backs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective					61
Annual Indicator		59.7	60.9	64.0	64.0
Numerator		27192	31201	32844	32844
Denominator		45575	51206	51339	51339
Data Source				Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	62	63	64	65	

Notes - 2009
Source: 2008 Oklahoma PRAMS. 2009 PRAMS data not yet available, hence 2008 used as provisional estimate.

95% CI: (60.3%, 67.5%)

Notes - 2008
Source: 2008 Oklahoma PRAMS.

95% CI: (60.3%, 67.5%)

Notes - 2007
Source: 2007 Oklahoma PRAMS.

95% CI: (57.2%, 64.6%)

a. Last Year's Accomplishments
According to 2008 Pregnancy Risk Assessment Monitoring System (PRAMS) data 64.0% of infants were placed on their backs to sleep most of the time. This is a statistically significant increase from 2000 when 54.1% of infants were placed on their backs to sleep. The Healthy People 2010 goal is for 70% of healthy newborns to be placed on their backs to sleep.

In January 2009, Oklahoma PRAMS began asking mothers two new questions on the topic of safe infant sleep. These questions were added to the survey to address the issue of safe infant sleep, more comprehensively than simply asking about sleep position. The new questions ask about frequency of bed sharing (how often is the infant placed on another sleep surface with someone else for any sleeping) and whether or not the mother recalled prenatal care discussions with her health care provider about infant safe sleep.

In November of 2008, a newsletter was sent to the Oklahoma Hospital Association notifying hospitals of an upcoming survey of hospital nurses. In January 2009, the survey was sent to Oklahoma hospitals that deliver more than 15 babies per year. Nurses were asked about the infant safe sleep policies, practices, and educational opportunities within their mother and baby unit. As a result of this survey, needs were identified regarding parent education, professional education, and promotion of safe sleep guidelines.

MCH, in collaboration with the Office of Perinatal Continuing Education at the University of Oklahoma Health Sciences Center, developed an online education course for nurses, identified a model hospital infant safe sleep policy, and assured continuing education credit was provided for nurses completing the online course. The online course, created by the Infant Safe Sleep Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality initiative, was made available on the Training Finder Real-Time Affiliate Integrated Network (TRAIN). Letters signed by the Commissioner of Health were mailed in September 2009 to nurses working in hospitals and birthing facilities informing them of the course. Letters were also sent to hospital administrators with survey results, information about the online education opportunity, and recommendation to utilize the Model Behavior Policy from First Candle. Links to this hospital policy and the online training tool were posted on the OSDH website in September 2009.

The infant safe sleep education online course was revised and made available in August 2009 to childcare providers through TRAIN. The online course was approved by Oklahoma Child Care Services at the Oklahoma Department of Human Services (OKDHS) as one hour of training for early care and education providers. Both the nursing and childcare versions of the infant safe sleep course were updated in September 2009 with the most current data and recommendations available. Initial contacts were made to collaborate with childbirth educators and offer similar training opportunities.

The Infant Safe Sleep Workgroup met monthly and focused on increasing safe sleep practices in Oklahoma. The workgroup drafted four culturally and linguistically appropriate brochures (African American, American Indian, Hispanic, and white) that included the same consistent safe sleep message. In November 2008, a focus group of childcare providers reviewed the brochures and provided feedback via a SurveyMonkey online survey. The workgroup also designed a web page that includes infant safe sleep information such as Frequently Asked Questions, safe sleep tips, crib safety, tummy time, and grief support.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Added new questions to the PRAMS to gather more comprehensive data on infant safe sleep				X
2. Conducted survey of Oklahoma birthing hospitals to gain information on infant safe sleep policies and staff education practices				X
3. Developed and provided an online continuing education course for nurses				X
4. Identified a model infant safe sleep policy for use by hospital				X
5. Provided hospital administrators with results of the hospital survey, information about the online training, and recommendation for a model hospital policy				X
6. Modified the online training and offered to childcare providers				X
7. Drafted culturally and linguistically appropriate brochures for different racial and ethnic populations			X	
8. Designed web pages on infant safe sleep as part of infant mortality reduction initiative			X	
9. Finalized page for community toolkit developed for infant mortality reduction initiative				X
10.				

b. Current Activities
The Infant Safe Sleep Workgroup, led by the Sudden Infant Death Syndrome (SIDS)/Infant Safe Sleep Coordinator in MCH, continues to meet monthly. In addition to the safe sleep education course for nurses, there are now safe sleep educational opportunities specifically created for home visitation programs, social service providers, and early care and education providers. Each of these trainings provides appropriate continuing education or training credit. Information about these training opportunities, as well as other safe sleep information is now available on the infant safe sleep web pages, which are part of the OSDH website for "Preparing for a Lifetime, It's Everyone's Responsibility", http://iio.health.ok.gov. The infant safe sleep workgroup members continue to reach out to various professionals to encourage utilization of the online training as well as the model safe sleep policy. Additionally, through partnerships of this workgroup, the OKDHS has placed written infant safe sleep messaging for parents' viewing daily on Electronic Benefits Transfer (EBT) machines at childcare centers.

c. Plan for the Coming Year
MCH will collaborate with the Oklahoma Hospital Association on the administration of an annual survey to hospitals that will provide information on hospital policy, staff education, and parent education related to infant safe sleep. Related, infant safe sleep is one of five focus areas that will be addressed through the Maternal-Infant Quality Care Collaborative. MCH will offer technical assistance implementing policy and training requirements adopted by the hospitals.

MCH will explore through input gained during the activities for the MCH Title V Block Grant Five Year Needs Assessment what other strategies might be used to positively impact this measure.

MCH will explore with Oklahoma State Medical Examiner's Office means of improving Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Death (SUID) data collection and accuracy of coding infant cause of death.

The Infant Safe Sleep Workgroup will continue to expand its membership to include state and community-based partners and refine its strategic plan.

County health department public health nurses, health educators, and other staff will be trained to spread the infant safe sleep message within their communities.

PRAMS data will continue to be used to monitor the effectiveness of the infant safe sleep activities. Co-sleeping will be measured in the latest version of PRAMS for infants born in 2009 through at least 2012. The data for 2009 infants will be available in late 2010.

E. Health Status Indicators

Introduction
See Forms 20 and 21.

Title V designated health status indicators are reviewed regularly as an integral assessment of program monitoring throughout each year. These indicators are a limited representation of the issues that must be tracked routinely to learn of important changes in health status that may be the result of system changes, including health care access, changes in the population or socio-economic shifts of sub-populations. These changes are dynamic and MCH receives relatively rapid feedback from local providers when significant changes impact the MCH health care structure. Moreover, MCH encourages local communities and local public health providers to monitor these same issues to better address changing needs and to assist the Title V Program in adjusting services and funding as needs indicate.

Some health status indicators are not recognized as being strong indicators for Oklahoma Title V programs (e.g., Temporary Assistance for Needy Families). Others, such as low birth weight, mortality and morbidity due to unintentional injury, provision of demographic information related to live births to women, and deaths to infants and children are used in planning and evaluation of services and are linked with national and state performance measures and related activities. Depending on the degree of changes in health status indicators, further exploration is conducted to identify causative factors leading to the change and potential interventions to impact.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.0	8.4	8.2	8.3	8.3
Numerator	4143	4509	4478	4532	4532
Denominator	51746	53985	54895	54708	54708
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Finalized 2009 birth data are not yet available, hence provisional 2008 birth data are used as estimate. Current as of 6/7/10.

95% CI: (8.0, 8.5) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. 2008 birth data are still provisional. Current as of 6/7/10.

95% CI: (8.0, 8.5) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Current as of 6/7/10.

95% CI: (7.9, 8.4) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The low birth rate for all live births increased slightly from 8.2 percent of live births in 2007 to 8.3 percent in 2008. In the main, the percentage of Oklahoma births born weighing less than 2,500 grams has shown little variation over the last five years.

MCH continues to examine the issue to understand better ways of impacting low birth rates in the

state. Work with the Perinatal Advisory Task Force (PATF) is on-going to explore the issue of designated levels of neonatal care in an effort to assure infants are delivered at the most appropriate facility. MCH has had initial discussions with OSDH Leadership about the history of self-designation by Oklahoma hospitals and the need to move to use of the American Academy of Pediatrics (AAP) standards in designation through changes in OSDH hospital regulatory rules.

Two workgroups of the "Preparing for a Lifetime, It's Everyone's Responsibility" statewide infant mortality initiative target efforts to address preconception/interconception health and prematurity in Oklahoma. The Preconception/Interconception Care and Education workgroup is focusing on educating women with previous poor pregnancy outcomes about the importance of early and appropriate prenatal care and the Prematurity workgroup is promoting awareness of the magnitude of this issue and interventions to decrease the rate of preterm births and associated morbidity and mortality.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #01A and efforts being made by the program in developing strategies to meet the HSI see NPMs #8, #15, #17 and #18 as well as SPM #1.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.4	6.8	6.6	6.7	6.7
Numerator	3221	3587	3530	3540	3540
Denominator	50190	52451	53351	53077	53077
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Finalized 2009 birth data are not yet available, hence provisional 2008 birth data are used as estimate. Current as of 6/7/10.

95% CI: (6.4, 6.9) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. 2008 birth data are still provisional. Current as of 6/7/10.

95% CI: (6.4, 6.9) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: Health Care Information, OSDH. Current as of 6/7/10.

95% CI: (6.4, 6.8) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
Among singleton live births, the low birth rate for all live births grew from 6.6 percent of live births in 2007 to 6.7 percent in 2008. The percentage of Oklahoma singleton live births born weighing less than 2,500 grams has risen significantly over the past ten years, from 6.0 in 1998 to 6.7 in 2008, an increase of almost 12 percent.

A toolkit designed specifically for the "Preparing for a Lifetime, It's Everyone's Responsibility" initiative will be used to educate the public on infant mortality and strengthen infant mortality reduction activities at the community level. As part of this statewide infant mortality reduction initiative, the Maternal-Infant Quality Care Collaborative will be implemented seeking voluntary participation of birthing hospitals from across the state to standardize care and education for females with high-risk perinatal conditions to help assure that prenatal care providers provide the same standard of care and education and transfer care as soon as appropriate to insure the best infant outcome. In current planning, it is anticipated that MCH will be the single point of contact for the hospitals in assuring their needs are identified and technical assistance provided.

Follow-up will occur to move discussions forward with key stakeholders to include the Oklahoma Hospital Association on changes that need to be made to OSDH rules regarding designated levels of neonatal care in hospitals.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #01B and efforts being made by the program in developing strategies to meet the HSI see NPMs #8, #15, #17, and #18 as well as SPM #1.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.4	1.6	1.4	1.4	1.4
Numerator	743	866	795	766	766
Denominator	51746	53985	54895	54708	54708
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Finalized 2009 birth data are not yet available, hence provisional 2008 birth data are used as estimate. Current as of 6/7/10.

95% CI: (1.30, 1.50) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008

Source: Health Care Information, OSDH. 2008 birth data are still provisional. Current as of 6/7/10.

95% CI: (1.30, 1.50) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: Health Care Information, OSDH. Current as of 6/7/10.

95% CI: (1.35, 1.55) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The rate of all live births weighing less than 1,500 grams remained constant at 1.4 percent during 2008. It represents an absolute decrease from 795 very low weight births in 2004 to 766 in 2008. The most recent low occurred in 2003 (1.2%).

Support of the Fetal and Infant Mortality Review (FIMR) projects' efforts to expand to the metropolitan statistical areas and to include fetal deaths will continue. Maternal Mortality Review (MMR) will be staffed and funded through MCH and will expand to include family interviews. Findings and recommendations from these multidisciplinary review processes will be used to make systems improvements to enhance positive outcomes for mothers and infants.

See NPMs #15, #17, and #18 for more on activities and plans the state has to improve the very low birth weight rate for infants.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.3	1.1	1.1	1.1
Numerator	585	664	600	610	610
Denominator	50190	52451	53351	53077	53077
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Finalized 2009 birth data are not yet available, hence provisional 2008 birth data are used as estimate. Current as of 6/7/10.

95% CI: (1.06, 1.24) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008

Source: Health Care Information, OSDH. 2008 birth data are still provisional. Current as of 6/7/10.

95% CI: (1.06, 1.24) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: Health Care Information, OSDH. Current as of 6/7/10.

95% CI: (1.03, 1.22) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
Among singleton live births, the percent of births born at very low birth weight did not change from 2007, holding constant at 1.1 percent in 2008.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #02B and efforts being made by the program in developing strategies to meet the HSI see NPMs #8, #15, #17, and #18 as well as SPM #1.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	13.9	15.9	14.9	14.9	14.9
Numerator	102	117	111	111	111
Denominator	733927	736421	745170	745170	745170
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator.

Since 2009 data are not yet available for the numerator and denominator, 2007 death and Census data are used as an estimate. Number of deaths current as of 6/7/10.

95% CI: (12.1, 17.7) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator.

Since 2008 data are not yet available for the numerator and denominator, 2007 death and Census data are used as an estimate. Number of deaths current as of 6/7/10.

95% CI: (12.1, 17.7) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator. Number of deaths current as of 6/7/10.

95% CI: (12.1, 17.7) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The unintentional death rate among children less than 15 years of age decreased by 6.3% to 14.9 per 100,000 population in 2007 from 15.9 in 2006. Generally speaking, this measure tends to vary from year-to-year, oscillating yearly from increases to decreases of moderate change. This is due to the small number of events used to compute the death rate.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #03A and efforts being made by the program in developing strategies to meet the HSI see NPM #10 and SPM #8.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.6	6.7	6.8	6.8	6.8
Numerator	34	49	51	51	51
Denominator	733927	736421	745170	745170	745170
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator. Number of deaths current as of 6/7/10.

Since 2009 data are not yet available for the numerator and denominator, 2007 death and Census data are used as an estimate.

95% CI: (5.0, 8.7) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator. Number of deaths current as of 6/7/10.

Since 2008 data are not yet available for the numerator and denominator, 2007 death and Census data are used as an estimate.

95% CI: (5.0, 8.7) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator. Number of deaths current as of 6/7/10.

95% CI: (5.0, 8.7) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The death rate for children 14 years and younger was 6.8 per 100,000 population in 2007, a marginal increase from 6.7 in 2006. The death rates in this category tend to vary year-to-year; thus, these findings should be interpreted cautiously, given the small number of events that are used in the computation of these rates. Single-year rates that include small counts of events are subject to wide variability.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #03B and efforts being made by the program in developing strategies to meet the HSI see NPM #10 and SPM #8.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	36.0	38.5	34.6	34.6	34.6
Numerator	190	202	181	181	181
Denominator	527537	524450	523251	523251	523251
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 15-24 in denominator. Number of deaths

current as of 6/7/10.

Since 2009 data are not yet available for the numerator and denominator, 2007 death and Census data are used as an estimate.

95% CI: (29.6, 39.6) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 15-24 in denominator. Number of deaths current as of 6/7/10.

Since 2008 data are not yet available for the numerator and denominator, 2007 death and Census data are used as an estimate.

95% CI: (29.6, 39.6) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 15-24 in denominator. Number of deaths current as of 6/7/10.

95% CI: (29.6, 39.6) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The death rate for youth aged 15-24 was down by 10.1%, dropping from 38.5 per 100,000 in 2006 to 34.6 in 2007. However, the death rates in this category tend to vary year-to-year; thus, these findings should be interpreted cautiously, given the small number of events that are used in the computation of these rates. Single-year rates that include small counts of events are subject to wide variability.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #03C and efforts being made by the program in developing strategies to meet the HSI see NPM #10 and SPM #8.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	340.7	340.7	313.4	313.4	313.4
Numerator	2498	2498	2335	2335	2335
Denominator	733102	733102	745170	745170	745170
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: 2007 death numbers from Health Care Information, OSDH, for numerator, Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator.

Since 2009 data are not yet available for the numerator and denominator, 2007 death and Census data are used as an estimate.

95% CI: (300.6, 326.1) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: Oklahoma inpatient hospital discharge data, 2007, Health Care Information Division, OSDH, for numerator. U.S. Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator. 2008 injury data are not available, therefore 2007 data are used as a provisional estimate.

95% CI: (300.6, 326.1) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: Oklahoma inpatient hospital discharge data, 2007, Health Care Information Division, OSDH, for numerator. U.S. Census Bureau July 1, 2007 OK population estimates for ages 14 and younger in denominator.

2007 95% CI: (300.6, 326.1)
2006 95% CI: (327.4, 354.1)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The nonfatal injury rate among children less than 15 years of age was 313.4 per 100,000 in 2007, a statistically significant decrease of 8.0% from 340.7 in 2006.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #04A and efforts being made by the program in developing strategies to meet the HSI see NPM #10 and SPM #8.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	427.7	440.4	422.5	367.8	367.8
Numerator	3139	3258	3148	2773	2773
Denominator	733927	739762	745170	753870	753870
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: 2008 injury numbers for numerator from Oklahoma Dept of Public Safety. July 1, 2008 OK population estimates for ages 14 and younger in denominator from Census Bureau. 2009 data are not yet available, hence 2008 data are used as provisional estimate.

95% CI: (354.1, 381.6) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: 2008 injury numbers for numerator from Oklahoma Dept of Public Safety. July 1, 2008 OK population estimates for ages 14 and younger in denominator from Census Bureau.

2008 95% CI: (354.1, 381.6)
2007 95% CI: (407.7, 437.2)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: 2007 injury numbers for numerator from Oklahoma Dept of Public Safety. July 1, 2007 OK population estimates for ages 14 and younger in denominator from Census Bureau.

95% CI: (407.7, 437.2)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The nonfatal motor vehicle crash rates for age groups 14 and younger have declined by 12.9%, dropping to 367.8 per 100,000 in 2008 from 422.5 in 2007, a statistically significant decrease. Moreover, the 2008 rate is down 16.5% from the 2006 rate of 440.4 per 100,000.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #04B and efforts being made by the program in developing strategies to meet the HSI see NPM #10 and SPM #8.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2,536.9	2,292.2	2,143.5	2,022.5	2,022.5
Numerator	13383	13450	11216	10559	10559
Denominator	527537	586769	523251	522081	522081
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: 2008 injury numbers for numerator from Oklahoma Dept of Public Safety. July 1, 2008 OK population estimates for ages 15-25 in denominator from Census Bureau. 2009 data are not yet available, hence 2008 data are used as provisional estimate.

95% CI: (1983.5, 2061.4) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: 2008 injury data are not available. 2006 injury numbers for ages 15-25 for numerator from Oklahoma Dept of Public Safety. July 1, 2006 OK population estimates for ages 15-25 for denominator from Census Bureau.

2008 95% CI: (1983.5, 2061.4)
2007 95% CI: (2103.4, 2183.6)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: 2007 injury numbers for ages 15-25 for numerator from Oklahoma Dept of Public Safety. July 1, 2006 OK population estimates for ages 15-25 for denominator from Census Bureau.

2007 95% CI: (2103.4, 2183.6)
2006 95% CI: (2253.0, 2331.4)
2005 95% CI: (2493.4, 2580.4)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The nonfatal motor vehicle crash rates for ages 15-24 have dropped 5.6% from 2143.5 per 100,000 in 2007 to 2022.5 in 2008, a statistically significant decrease. This continues a trend of steady decline nonfatal motor vehicle crash rates for ages 15-24 during the past four years, with a net decrease of 20.3% from a rate of 2536.9 per 100,000 in 2005 to 2022.5 in 2008.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #04C and efforts being made by the program in developing strategies to meet the HSI see NPM #10 and SPM #8.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	30.3	31.5	29.8	36.5	36.5
Numerator	3649	3838	3661	4439	4439
Denominator	120619	121799	122723	121642	121642
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: HIV/STD Service, OSDH for numerator, July 1, 2008 Census Bureau estimate for women aged 15-19 years in denominator. 2009 chlamydia data are not available, hence 2008 data are used as a provisional estimate.

95% CI: (35.4, 37.6) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: HIV/STD Service, OSDH for numerator, July 1, 2008 Census Bureau estimate for women aged 15-19 years in denominator.

2008 95% CI: (35.4, 37.6)
2007 95% CI: (28.9, 30.8)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: HIV/STD Service, OSDH for numerator, July 1, 2007 Census Bureau estimate for women aged 15-19 years in denominator.

2007 95% CI: (28.9, 30.8)
2006 95% CI: (30.5, 32.5)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The chlamydia case rates for females aged 15-19 rose in 2008. For ages 15-19, the rate rose 22.5% to 36.5 per 1,000 females from 29.8 in 2007. This is a statistically significant increase following a period of relatively flat rates from 2002 to 2007, which cannot be wholly attributed to expected random fluctuations from year to year.

MCH works closely with the Oklahoma State Department of Health HIV/STD Service on a Centers for Disease Control and Prevention (CDC) funded regional infertility project. This project focuses on education, screening, and treatment to reduce the incidence of Chlamydia infection in females and males receiving Title X family planning services.

Two workgroups of the "Preparing for a Lifetime, It's Everyone's Responsibility" statewide infant mortality initiative target efforts to address preconception/interconception health and maternal infections in Oklahoma. The Preconception/Interconception Care and Education Workgroup is focusing on educating females about the importance of overall health and early and appropriate prenatal care, to include testing for sexually transmitted infections. The Maternal Infections Workgroup is focusing on reducing the rates of maternal infections to reduce adverse pregnancy and birth outcomes.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.1	9.2	9.0	10.8	10.8
Numerator	5443	5514	5399	6463	6463

Denominator	595576	601498	602273	600385	600385
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: HIV/STD Service, OSDH for numerator, July 1, 2008 Census Bureau estimate for women aged 20-44 years in denominator. 2009 chlamydia data are not available, hence 2008 data are used as a provisional estimate.

95% CI: (10.5, 11.0) calculated using formula
SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2008
Source: HIV/STD Service, OSDH for numerator, July 1, 2008 Census Bureau estimate for women aged 20-44 years in denominator.

2008 95% CI: (10.5, 11.0)
2007 95% CI: (8.7, 9.2)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Notes - 2007
Source: HIV/STD Service, OSDH for numerator, July 1, 2007 Census Bureau estimate for women aged 20-44 years in denominator.

95% CI: (8.7, 9.2)
calculated using formula SE(Rate)=(N/D^2+N^2/D^3)^1/2

Narrative:
The chlamydia case rate has seen a similar rise among females aged 20-44. After a period of little change in the chlamydia rates among females aged 20-44 during 2005-2007, the chlamydia rate rose sharply (20.0%) in 2008 to 10.8 per 1,000 from 9.0 in 2007.

MCH works closely with the Oklahoma State Department of Health HIV/STD Service on a Centers for Disease Control and Prevention (CDC) funded regional infertility project. This project focuses on education, screening, and treatment to reduce the incidence of Chlamydia infection in females and males receiving Title X family planning services.

Two workgroups of the "Preparing for a Lifetime, It's Everyone's Responsibility" statewide infant mortality initiative target efforts to address preconception/interconception health and maternal infections in Oklahoma. The Preconception/Interconception Care and Education Workgroup is focusing on educating females about the importance of overall health and early and appropriate prenatal care, to include testing for sexually transmitted infections. The Maternal Infections Workgroup is focusing on reducing the rates of maternal infections to reduce adverse pregnancy and birth outcomes.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	54677	37807	5609	4861	1090	74	5236	0
Children 1 through 4	217184	154200	21031	22272	3643	333	15705	0
Children 5 through 9	254288	185384	24444	23652	4062	379	16367	0
Children 10 through 14	241609	174256	24115	24369	3944	284	14641	0
Children 15 through 19	256841	184627	27384	26999	4174	287	13370	0
Children 20 through 24	280782	205781	28191	26592	6618	362	13238	0
Children 0 through 24	1305381	942055	130774	128745	23531	1719	78557	0

Notes - 2011
Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Narrative:
According to the American Community Survey (ACS), in 2009, the latest for which detailed race/ethnicity data are available, there were an estimated 1,305,381 children in Oklahoma between the ages 0 and 24. Four percent were infants and nearly 17% were children ages 1-4.

Approximately 19% were children ages 5-9, with another 19% aged 10-14 years and 20% aged 15-19. Roughly 22% of the 1.3 million children were aged 20-24. Over seven in ten (72%) Oklahoma children are classified as white, with another 10% considered American Indian/Alaska Native and 10% African American. Less than 2% of Oklahoma children are classified as Asian race. The fraction of Oklahoma's population under 25 years of age has declined slightly over the past nine years, from 36.2% in 2000 to 35.4% in 2009.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**

HISPANIC ETHNICITY			
Infants 0 to 1	46828	7849	0
Children 1 through 4	182481	34703	0
Children 5 through 9	218489	35799	0
Children 10 through 14	214392	27217	0
Children 15 through 19	231345	25496	0
Children 20 through 24	254368	26414	0
Children 0 through 24	1147903	157478	0

Notes - 2011
Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: U.S. Census Bureau, July 1, 2009 population estimates.

Narrative:
In 2009, the latest for which detailed race/ethnicity data are available, the ACS data reveal that 12.1% of Oklahoma children aged 0 through 24 years are of Hispanic origin. The fraction of Oklahoma children who are Hispanic has grown by over 50% during the past nine years, from 8.0% in 2000 to 12.1% in 2009.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	89	48	24	15	0	2	0	0
Women 15 through 17	2297	1532	332	403	0	19	0	11
Women 18 through 19	5190	3602	656	876	2	43	0	11
Women 20 through 34	42681	32913	3703	4896	89	823	0	257
Women 35 or older	4460	3555	294	314	36	238	0	23
Women of all ages	54717	41650	5009	6504	127	1125	0	302

Notes - 2011

Narrative:

In 2007, the latest year for which final birth data are available, there were 54,717 births to Oklahoma residents, a 1.3% increase from the number of births in 2006 (54,010).

Approximately 14% of Oklahoma births are to women under the age of 20, resulting in no real change in the proportion of all births occurring to this age group. Another 8% of births occur to women 35 or older.

Over three out of four births (76%) in Oklahoma occur to white mothers. African American and American Indian/Alaska Native births make up 9.2% and 11.9%, respectively, of all Oklahoma births. Just 0.2% of Oklahoma births are births occurring to women of Asian descent.

The Oklahoma birth rate among females of ages 15 to 19 decreased 0.4% from 61.8 births per 1,000 in 2007 to 61.6 in 2008 (provisional data), reversing two years of increase in 2006 and 2007 that had interrupted a long-term decline in teen birth rates in Oklahoma. A decrease in teen birth rates in 2008 has likewise been observed nationally (provisional data), although of larger magnitude (2.0%). The white teen birth rate was 58.8 births per 1,000 in 2008, a slight drop of 0.2% from 59.0 in 2007. The 2008 birth rates among African American women of ages 15 to 19 was 77.7 births per 1,000 in 2008, an increase of 1.8% from 76.3 in 2007. The 2008 birth rates among American Indian/Alaska Native women of ages 15 to 19 was 95.7 births per 1,000 in 2008, a decrease of 1.5% from 97.1 in 2007.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	63	26	0
Women 15 through 17	1827	468	0
Women 18 through 19	4498	688	0
Women 20 through 34	37391	5253	0
Women 35 or older	3830	630	0
Women of all ages	47609	7065	0

Notes - 2011

Narrative:
In 2007, the latest year for which final birth data are available, there were 54,717 births to Oklahoma residents, a 1.3% increase from the number of births in 2006 (54,010).

Approximately 14% of Oklahoma births are to females under the age of 20, resulting in no real change in the proportion of all births occurring to this age group. Another 8% of births occur to women 35 or older.

According to provisional 2008 birth data, nearly 13% of all live births in Oklahoma occurred to Hispanic mothers in 2008, with females of Mexican origin making up the majority (88.1%) of Hispanic mothers.

According to provisional 2008 birth data, the Hispanic teen birth rate was 108.7 births per 1,000 in 2008, a decrease of 2.3% from 111.2 in 2007. Births to Non-Hispanic women ages 15 to 19 were

substantially lower, at 57.0 births per 1,000 in both 2008 and 2007.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	468	275	85	58	1	0	20	29
Children 1 through 4	85	53	14	8	0	0	4	6
Children 5 through 9	60	34	10	8	1	0	3	4
Children 10 through 14	51	33	10	4	0	0	4	0
Children 15 through 19	210	141	30	21	0	0	6	12
Children 20 through 24	305	203	39	31	4	0	6	22
Children 0 through 24	1179	739	188	130	6	0	43	73

Notes - 2011

Narrative:
According to provisional 2007 data, there were 1,179 deaths to children 0 to 24 years of age during 2007. Forty percent of the child deaths occurred to infants. Young adults aged 20-24 made up the second largest proportion (25.9%) of deaths to children 0-24. Another 17.8% of child deaths occurred to the adolescent age group 15-19 years. Approximately six in ten (62.7%) child deaths occurred to white children. African American and American Indian/Alaska Native children made up 15.9% and 11.0% of the Oklahoma child deaths in 2007.

While Oklahoma's infant mortality rate saw a long term decline during the 20th century, it has changed little during the past decade. The provisional infant mortality rate in 2007 was 8.5 per 1,000, compared with 8.4 in 2000.

According to provisional 2007 data, the death rate among Oklahoma children 0 to 24 years of age was 91.6 per 100,000 in 2007, an increase of 1.5% from 2006 when the rate was 90.2 deaths per 100,000. The death rate in this age group rose from 82.1 deaths per 100,000 in 2000 to 91.6 in 2007, an increase of 11.6%. Much of the increase during this period is explained by a significant increase of 22.5% in the death rate among African-American children, from 128.9 deaths per 100,000 in 2000 to 158.0 in 2007, and a steep increase of 55.2% in the death rate among American Indian/Alaska Native children, from 64.0 deaths per 100,000 in 2000 to 99.3 in 2007.

MCH provides leadership for multiple activities to impact this indicator: the Child Death Review Board, Fetal and Infant Mortality Review, and the "Preparing for a Lifetime, It's Everyone's Responsibility" initiative.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #08A and efforts being made by the program in developing strategies to meet the HSI see NPMs #10

and #16 and SPMs #8 and #11.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	415	48	5
Children 1 through 4	71	10	4
Children 5 through 9	54	4	2
Children 10 through 14	50	1	1
Children 15 through 19	193	11	5
Children 20 through 24	277	24	4
Children 0 through 24	1060	98	21

Notes - 2011

Narrative:
About eight percent of child deaths occurred to children of Hispanic origin in 2007.

MCH provides leadership for multiple activities to impact this indicator: the Child Death Review Board, Fetal and Infant Mortality Review, and the "Preparing for a Lifetime, It's Everyone's Responsibility" initiative.

For a more detailed summary of influences on the ability to maintain and/or improve HSI #08B and efforts being made by the program in developing strategies to meet the HSI see NPMs #10 and #16 and SPMs #8 and #11.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1024599	736274	102583	102153	16913	1357	65319	0	2009
Percent in household headed by single parent	31.4	26.7	66.2	36.4	14.9	27.1	41.9	31.5	2008
Percent in TANF (Grant) families	1.6	0.9	5.5	2.0	0.8	0.0	0.0	0.0	2008

Number enrolled in Medicaid	536776	365703	79307	69514	6806	823	14623	0	2009
Number enrolled in SCHIP	116988	85652	11549	15627	1828	118	2214	0	2009
Number living in foster home care	9309	4969	2509	1796	35	0	0	0	2009
Number enrolled in food stamp program	305999	187583	66360	48711	3345	0	0	0	2009
Number enrolled in WIC	199320	135971	21641	11219	2594	937	26958	0	2009
Rate (per 100,000) of juvenile crime arrests	2404.2	2167.6	6850.4	1548.3	949.4	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.3	2.2	2.5	2.4	1.9	0.0	0.0	0.0	2009

Notes - 2011
Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: Table S0901 (Children Characteristics) from 2006-2008 American Community Survey.

Source: Oklahoma Department of Human Services, FY2008 Annual Report (to match most recent U.S. Census Bureau population estimates from 2008 for denominator).

FY2009 children enrolled in TANF by race:
White: 6,522
Black: 5,164
AI/AN: 1,924
Asian: 119

Source: OHCA data warehouse extract 4/6/2010, Federal Fiscal Year 2009.

Source: OHCA data warehouse extract 4/6/2010, Federal Fiscal Year 2009.

Source: Oklahoma Department of Human Services, FY2009 data request. All races are Non-Hispanic.

Source: Oklahoma WIC, 2009.

Source: Oklahoma State Bureau of Investigation, State of Oklahoma Uniform Crime Report, Annual Report, January-December 2008.

Source: Oklahoma State Department of Education, 2008-2009 Application for Accredittation enrollment figures for accredited public high schools and 2008-2009 Dropout Report.

Source: Oklahoma Department of Human Services, FY2009 Annual Report, Table 21 (Out-of-Home Care Placements).

Narrative:
Nearly 1 in 3 (31.4%) Oklahoma children aged 0 to 19 lived in a single-parent household during 2006-2008. Rates differed dramatically by race: White 26.7%, African American 66.2%, and American Indian/Alaska Native 36.4%.

Approximately 52% of Oklahoma children in this age group were enrolled in the Medicaid program during 2009, while 11% were enrolled in the Oklahoma's State Children's Health Insurance Program (SCHIP). There were significant racial disparities in Medicaid participation rates during 2009, while SCHIP participation rates were comparable. Roughly 50% of white children were enrolled in the Medicaid program, while 79% of African American children, and 68% of American Indian/Alaska Native children were enrolled in Medicaid.

Almost one percent of all children 0 to 19 years of age were living in foster home care in 2009. Among white children, 0.6% were in foster care, but the foster care rate is four times higher among African American children, at 2.4%. Thirty percent of children 0 to 19 years of age in Oklahoma were enrolled in a food stamp program during 2009, and 19% were enrolled in WIC. Again there were large racial disparities in food stamp participation rates, although WIC participation rates were similar across racial categories. Twenty-five percent of white children were enrolled in a food stamp program in 2009, compared with 65% of African American children and 48% of American Indian/Alaska Native children.

The juvenile crime rate in Oklahoma stood at 2,404 juvenile crime arrests per 100,000 among children 0-17 years of age in 2008, an increase of 1.1% from the juvenile arrest rate of 2,168 in 2007. The annual juvenile arrest rate in Oklahoma has decreased by over 17% during the period 2000-2008 from a high of 2,900 in 2000, although since 2005 the juvenile arrest rate has leveled off. The juvenile crime rate among white children was 2,167 arrests per 100,000 in 2008, while the crime rate for African-American youth was over three times higher, at 6,850 arrests per 100,000.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	893535	131064	0	2009
Percent in household headed by single parent	26.4	33.3	0.0	2008
Percent in TANF (Grant) families	1.6	1.7	0.0	2008
Number enrolled in Medicaid	455178	81598	0	2009
Number enrolled in SCHIP	99333	17655	0	2009
Number living in foster home care	9309	1624	0	2009
Number enrolled in food stamp program	305999	37609	0	2009
Number enrolled in WIC	143181	56139	0	2009
Rate (per 100,000) of juvenile crime arrests	2514.5	1639.7	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.2	3.4	0.0	2009

Notes - 2011
Source: U.S. Census Bureau, July 1, 2009 population estimates.

Source: Table S0901 (Children Characteristics) from 2006-2008 American Community Survey.

Source: Oklahoma Department of Human Services, FY2008 Annual Report (to match most recent U.S. Census Bureau population estimates from 2008 for denominator).

FY2009 children enrolled in TANF by Hispanic origin
Non-Hispanic: 13,729
Hispanic: 2,102

Source: OHCA data warehouse extract 4/6/2010, Federal Fiscal Year 2009.

Source: OHCA data warehouse extract 4/6/2010, Federal Fiscal Year 2009.

Source: Oklahoma Department of Human Services, FY2009 data request. Hispanics are reported as a separate racial category.

Source: Oklahoma WIC, 2009.

Source: Oklahoma State Bureau of Investigation, State of Oklahoma Uniform Crime Report, Annual Report, January-December 2008.

Source: Oklahoma State Department of Education, 2008-2009 Application for Accredittation enrollment figures for accredited public high schools and 2008-2009 Dropout Report.

Source: Oklahoma Department of Human Services, FY2009 Annual Report, Table 21 (Out-of-Home Care Placements).

Narrative:
One-third of Hispanic children (33.3%) lived in single parent households in 2009, compared with 26.4% for Non-Hispanic children. Sixty two percent of Hispanic children were enrolled in Medicaid during 2009, significantly higher than the Non-Hispanic Medicaid participation rate of 51%. Enrollment rates in SCHIP and food stamp programs were similar, however disproportionately more Hispanic children rely on WIC than Non-Hispanic children, at 43% versus 16% in 2009.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	646275
Living in urban areas	670348
Living in rural areas	342967
Living in frontier areas	11284
Total - all children 0 through 19	1024599

Notes - 2011

Source: U.S. Census Bureau. Metropolitan population calculated from July 1, 2009 population estimate of children 0-19 years of age residing in Oklahoma MSA counties: Canadian, Cleveland, Comanche, Creek, Garfield, Logan, McClain, Oklahoma, Osage, Pottawatomie, Rogers, Sequoyah, Tulsa, and Wagoner.

Source: U.S. Census Bureau. Urban population calculated from total number of children 0-19 years of age residing in Oklahoma counties with July 1, 2009 population estimate >50,000: Canadian, Cleveland, Comanche, Creek, Garfield, Grady, Muskogee, Oklahoma, Payne, Pottawatomie, Rogers, Tulsa, Wagoner, and Washington.

Source: U.S. Census Bureau. Rural population calculated from total number of children 0-19 years of age residing in Oklahoma counties with July 1, 2009 population estimate < 50,000, excluding frontier rural counties: Adair, Atoka, Beckham, Blaine, Bryan, Caddo, Carter, Cherokee, Choctaw, Coal, Cotton, Craig, Custer, Delaware, Garvin, Greer, Haskell, Hughes, Jackson, Jefferson, Johnston, Kay, Kingfisher, Kiowa, Latimer, Le Flore, Lincoln, Logan, Love, McClain, McCurtain, McIntosh, Major, Marshall, Mayes, Murray, Noble, Nowata, Okfuskee, Okmulgee, Osage, Ottawa, Pawnee, Pittsburg, Pontotoc, Pushmataha, Seminole, Sequoyah, Stephens, Texas, Tillman, Washita, Woodward.

Source: U.S. Census Bureau. Frontier rural population calculated from total number of children 0-19 years of age residing in Oklahoma counties with July 1, 2009 population density < 7 people per square mile: Alfalfa, Beaver, Cimarron, Dewey, Ellis, Grant, Harmon, Harper, Roger Mills, and Woods.

Narrative:
In 2009, ACS data estimated 1,024,599 children aged 0-19 lived in Oklahoma, a growth of 1.2% from 1,012,229 children in 2008. Approximately 63% of these children resided in metropolitan areas. Sixty-five percent of Oklahoma children live in urban areas, with the remainder living in rural (33.5%) and frontier (1.1%). This most recent geographic population data shows a small increase in the proportion of children residing in urbanized areas of the State.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	3687050.0
Percent Below: 50% of poverty	5.6
100% of poverty	13.6
200% of poverty	33.2

Notes - 2011
Source: U.S. Census Bureau 7/1/2009 State Characteristics Population Estimates.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2009.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2009.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2009.

Narrative:
According to the Current Population Survey in 2009, there were an estimated 3,687,050 individuals residing in Oklahoma, an increase of 1.2% from 2008. The year 2009 saw an increase in the percentage of Oklahomans living below the federal poverty level (FPL), likely a result of the economic recession. For Oklahomans at 100% FPL, the percentage increased from 13.4% to 13.6%, while that percentage at the lower end of the income to poverty ratio scale (<50% FPL) rose to 5.6% from 5.0%. The percentage of individuals living at or below 200% FPL decreased from 36.3% to 33.2%.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1024599.0
Percent Below: 50% of poverty	9.9
100% of poverty	21.1
200% of poverty	44.6

Notes - 2011
Source: U.S. Census Bureau 7/1/2009 State Characteristics Population Estimates.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2009.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2009.

Source: U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement 2009.

Narrative:
More children dropped below the federal poverty level in 2009. Current Population Survey data indicate that in 2009 the estimated percentage of Oklahoma children less than 20 years of age under 50% of the federal poverty level (FPL) increased to 9.9% from 7.5% in 2008. The percentage of children in Oklahoma living at or below 100% of the FPL also increased, from 18.8% to 21.1%. The percentage of children living at or below 200% of the FPL decreased from 45.3% to 44.6% of the FPL between 2008 and 2009.

F. Other Program Activities

The Oklahoma Areawide Services Information System (OASIS) is the statewide toll free information and referral line for MCH and CSHCN (see Form 9). The telephone number for the Hotline is 1-800-OASIS. The OASIS is in operation Monday - Friday from 8:00 AM to 6:00 PM with an answering machine for after-hours calls. Individuals who leave a message after hours are contacted the following workday. TDD/TTY services for the deaf are available and bilingual staff are available to those who speak Spanish. The OASIS also maintains a website (http://oasis.ouhsc.edu/) for information and referral services. Oklahoma 211 works closely with

the OASIS as 211 relies on the OASIS as their primary information and referral resource for MCH populations, to include CSHCN.

MCH accomplishes a Comprehensive Program Review in each county health department administrator's area every four years. The MCH Comprehensive Program Review involves a multidisciplinary team traveling to an Administrator's area and assessing infrastructure, population-based, enabling, and direct health services for the MCH population. A report is prepared and forwarded to the Administrator outlining requirements and recommendations as well as timelines for addressing findings. During interim years, technical assistance visits are completed to include annual visits to observe clinical practices of nurse practitioners.

Contract providers receive a minimum of one required onsite visit each year. At the beginning of the contract year, each contractor completes a risk assessment that assists in developing the annual monitoring plan. Depending on the final risk score, the monitoring plan is adjusted to reflect any additional onsite visits that must be made beyond the one required visit. Technical assistance visits are also accomplished as identified or requested.

CSHCN continues to provide site visits to all contract providers. The main focus at these visits is to discuss how contractor activities are tied to the national and state performance measures of CSHCN.

Injury prevention activities continue to be a focus. MCH provides technical assistance and state funding for the Oklahoma Poison Control Center. The Poison Control Center operates 24 hours a day, 365 days per year using specially trained licensed pharmacists and nurses who provide emergency poisoning management advice to Oklahoma residents and health care professionals. This year, MCH assumed the lead from the Oklahoma State Department of Health (OSDH) Injury Prevention Service for working with the Oklahoma State Department of Education (OSDE), schools, and families on bullying prevention activities. Routine communications and meetings with the OSDE and quarterly meetings with Injury Prevention Service assure ongoing coordination of activities.

MCH funds the Oklahoma Birth Defects Registry (OBDR). The OBDR is a public health surveillance project that monitors the status of children born with birth defects in Oklahoma. Characteristics of the OBDR include: statewide, population based, active surveillance; Oklahoma residents who deliver infants in Oklahoma; age range includes birth to 2 years of age; and, all live births and stillbirths diagnosed with a birth defect (CDC/BPA codes). Activities of the OBDR consist of referral of children with birth defects to the SoonerStart (Oklahoma's zero to three early intervention program), statewide folic acid education campaign for neural tube defect (NTD) prevention, and rapid ascertainment of infants born with NTDs from tertiary hospitals, including recurrence prevention education of NTDs.

The Oklahoma Vision Screening Advisory Committee for Children created in 2007 through Senate Bill 1795 is staffed by MCH. In addition to assuring activities of the committee are moved forward, MCH also provides training to individuals desiring to become vision screeners.

House Bill 1051, passed in 2007, created the Diabetes Management in Schools Act. This act requires that a diabetes medical management plan be developed for each student with diabetes who will seek care for diabetes while at school or while participating in a school activity. During each school year, the School Health Coordinator in MCH provides diabetes management training for school personnel throughout the state in collaboration with the OSDH Chronic Disease Service and OSDE.

With the OSDH being designated as the lead agency by Governor Brad Henry to make application for the recently released Funding Opportunity Announcement (FOA) by the Health Resources and Services Administration, Maternal and Child Health Bureau entitled, "Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program", MCH is working

on the required state needs assessment for this FOA due September 1. The OSDH Family Support and Prevention Service, which administers two statewide home visitation program models (the Nurse Family Partnership model and the Healthy Families model), is the lead for the application with MCH providing technical assistance and serving as a resource to assure planning aligns with statewide infant mortality and early childhood activities as well as other Title V priorities.

G. Technical Assistance

As MCH partners with the Oklahoma Hospital Association, Oklahoma Health Care Authority, Office of Perinatal Continuing Education at the University of Oklahoma Health Sciences Center, and March of Dimes on implementation of the Maternal-Infant Quality Care Collaborative with birthing hospitals across the state, technical assistance may be requested from other states in the nation who have experience with this type of collaborative. Due to budgetary constraints, funds are not available among any of the partners to implement the collaborative as envisioned. Initial steps will be to attempt to engage birthing hospitals to participate voluntarily by offering tools and technical assistance to develop policies and provide staff education to impact elective deliveries, breastfeeding, infant safe sleep, abusive head trauma, and tobacco use prevention. During an initial meeting earlier this year with representation from approximately half the birthing hospitals in the state, the concept of a collaborative was introduced and received with positive responses from hospital administration.

A written invitation will be sent this summer to all birthing hospitals under the signature of the Commissioner of Health and the Executive Director of the Oklahoma Hospital Association inviting administration of the hospitals to participate in a one day meeting in September, National Infant Mortality Awareness Month. During the meeting, hospitals will be informed of support to be offered, how the support will assist them in meeting of standard quality indicators, and how to go about obtaining the support. Input will also be requested from the hospitals about how to best provide the offered support. Based on information gained from hospitals during the one-day meeting and issues encountered as the collaborative is implemented, technical assistance may be requested.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	7401402	7290174	7253654		7290174	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	5611170	8216077	5500846		5528288	
4. Local MCH Funds *(Line4, Form 2)*	0	5564423	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	128367	182587	105413		176000	
7. Subtotal	13140939	21253261	12859913		12994462	
8. Other Federal Funds *(Line10, Form 2)*	4434656	4434656	4793329		4481363	
9. Total *(Line11, Form 2)*	17575595	25687917	17653242		17475825	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2914741	3283634	2826977		1672737	
b. Infants < 1 year old	1338037	3763664	1286944		1917272	
c. Children 1 to 22 years old	3871635	8800146	3856679		4482939	
d. Children with	3895474	3836933	3817713		3836933	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	1121052	1568884	1071600		1084581	
g. SUBTOTAL	13140939	21253261	12859913		12994462	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		93713	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	132827		128172		138173	
j. Education	48635		48635		48635	
k. Other						
ECCS	142692		105000		140000	
Family Planning	4015858		4416878		4060842	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	6622185	8692608	5800981		5681802	
II. Enabling Services	903676	1576806	858935		917998	
III. Population-Based Services	2061786	4621555	2377400		2690613	
IV. Infrastructure Building Services	3553292	6362292	3822597		3704049	
V. Federal-State Title V Block Grant Partnership Total	13140939	21253261	12859913		12994462	

A. Expenditures

See Forms 2, 3, 4 and 5

The Oklahoma State Department of Health (OSDH) MCH value for parts A, B and C is determined through the OSDH time and effort reporting system in which all state and local staff code their daily time to program activities. Non-personnel expenses are made as direct charges to the appropriate program budgets. State funds include state and county appropriations for local health departments. Other contributions include in-kind monies. Program income includes fee revenues from Medicaid. The OSDH is audited each year by the state auditor's office following the federal guidelines applicable to the MCH Title V Block Grant. All appropriate fiscal records are maintained to insure audit compliance.

The Oklahoma Department of Human Services (OKDHS) CSHCN value is determined through the Random Moment Time Study (RMTS) and based on employees' responses specifically

related to the CSHCN Program. All Field Operations Division and Family Support Services Division field staff that work multi-funded programs are sampled in the RMTS. RMTS sampling is a federally approved technique for estimating the actual distribution of worker time to various activities when numerous federal funding sources exist. The percentage of employees' responses to CSHCN-related tasks compared to responses to all other federal and/or state programs in the RMTS constitutes the value of costs directly charged quarterly to the CSHCN Program. Payroll, benefits, travel, etc., for RMTS participants are allocated proportionately based on RMTS responses.

The Oklahoma Title V Program continually looks for opportunities to realign funding for core infrastructure, population-based and enabling services while assuring critical gap-filling direct health care services are maintained. Expansion of coverage of direct health care services through Medicaid for MCH populations over recent years has assisted the Title V Program to accomplish critical realignments to benefit Oklahoma in having needed data and evaluation available for policy and services decisions, quality improvement activities, training for health care providers, public education and improved coordination among health and human services agencies.

B. Budget

Maintenance of effort from 1989:
For 1989, the OSDH administered 77.5 percent of the MCH Title V Block Grant funds and the OKDHS administered 22.5 percent of the funds. Even with this split, 1/3 of the available dollars were spent on CSHCN activities. The amount of the award for 1989 was $5,980,100. The OSDH share was $4,634,578 and the OKDHS received $1,345,522.

The OSDH expenditure reports indicate that a total of $4,634,578 of MCH Title V Block funds was expended during the grant period October 1, 1988 through September 30, 1989. For that period, a total $4,109,415 of the OSDH and county health department resources were expended for Block Grant activities. The amount of state/local expenditures exceeded the required match of $3,475,932 by an amount of $633,483.

Summary -- Federal Fiscal Year (FFY) 1989 Block Grant Expenditures

	State Health Department	Department of Human Services	Total
Title V	$4,634,578	$1,345,522	$5,980,100
Match	$3,475,932	$1,061,546	$4,537,478
Overmatch	$146,839	0	$146,839
Income	$250,000	0	$250,000
Local/Other	$236,644	0	$236,644
Total	$8,743,993	$2,407,068	$11,151,061

Special consolidated projects:
MCH Title V Block Grant funds continue to be used to carry out Sudden Infant Death Syndrome (SIDS) activities and the CSHCN Supplemental Security Income-Disabled Children's Program

(SSI-DCP). SIDS activities include public education and technical assistance/resource provision at the community level. The Public Health Social Work Coordinator in MCH is responsible for coordination of SIDS activities. The CSHCN SSI-DCP uses funds to provide diapers, formula, durable medical equipment, supplies and services that would otherwise not be available to children with special health care needs.

State matching funds:
In 2009, the OSDH made a policy decision to provide cost sharing in grant applications based on the requirements in each specific grant. For the MCH Title V Block Grant, cost sharing is based on the three state dollars for each four federal dollars as well as the requirement to meet the maintenance of effort set in 1989.

Federal 30/30 requirement:
For FFY 2011, 51.59 percent of the federal Title V Block Grant funds are designated for programs for preventive and primary care services for children and 30% for services for children with special health care needs. See Form 2.

State provides a reasonable portion of funds to deliver services:
The OSDH uses MCH funds towards programs of priority for state and local needs. Assistance is provided to state and local agencies to: 1) identify specific MCH areas of need; 2) plan strategies to address identified needs; and, 3) provide services to impact needs. Allocation of resources to local communities will continue to be based on factors such as: the identified need and scope of the particular health problem; community interest in developing service(s)/implementing evidenced-based practice(s) to eliminate the problem, including the extent and ability to which local resources are made available; ability to recruit the specialized staff which are often needed to carry out the proposed service; the cost effectiveness of the service to be provided; coordination with existing resources to assure non-duplication of services; and, periodic evaluation to determine if resources have impacted the problem.

The OKDHS administers the CSHCN Program through the Family Support Services Division (FSSD), Health Related and Medical Services Section. The FSSD also administers the SSI-DCP for SSI recipients to age 18. Other components of the CSHCN Program include two projects that support neonates and their families; support of the state Title V 1-800 toll-free information and referral system; sickle cell services; respite care services for medically fragile children; medical, psychological and psychiatric services to the CSHCN population in the custody of the OKDHS; funding for travel, training and child care for parents of children with special health care needs; a project that is establishing an integrated community-based system of services for children with special health care needs in several communities in the state; funding for a statewide mentorship program for families of children with special needs; and, funding of two parent advocates on a team that provides multi-disciplinary services to children in the autism clinic. Coordination continues between the FSSD and the Oklahoma Health Care Authority (OHCA) to assure services are not duplicated and policies and procedures are in compliance with federal and state mandates. The FSSD continues to utilize Title V funding to assure the development of community-based systems of services for children with special health care needs and their families.

Other federal programs or state funds within MCH to meet needs and objectives:
The State Systems Development Initiative (SSDI), a grant funded by the Maternal and Child Health Bureau (MCHB), supports activities to link Women, Infants and Children Supplemental Nutrition Program (WIC) data with birth certificates and Medicaid eligibility and claims data. This compliments and strengthens MCH's activities to link relevant program services to existing MCH databases including the Pregnancy Risk Assessment Monitoring System (PRAMS) and The Oklahoma Toddler Survey (TOTS) surveillance systems. These linkages enable the state to generalize the results to Oklahoma's population of pregnant women (or new mothers) and young children.

The Early Childhood Comprehensive Systems Initiative (ECCS), a grant funded by the MCHB, provides funds to assist Oklahoma in efforts to build and integrate early childhood services systems that address the critical components of access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education; and, family support. Implementation is being accomplished as a collaborative effort of state and community-based public and private partners.

The Pregnancy Risk Assessment Monitoring System (PRAMS), funded by the Centers for Disease Control and Prevention (CDC) with additional funds provided by MCH, provides population-based data on maternal and infant health issues. This information is used to educate health care providers on maternal and infant health issues; recommend health care interventions; monitor health outcomes; and, provide support for state policy and services changes.

The Oklahoma State Department of Education (OSDE) provides federal funds received from the CDC to the OSDH through a contractual agreement. MCH uses these funds to support ongoing administration of the Youth Risk Behavior Survey (YRBS). This survey provides Oklahoma with information on risk-taking behaviors of youth.

State perinatal and general revenue funds are received to support key MCH activities such as gap-filling maternity and child health clinical services; outreach; infant mortality reduction through preconception and interconception care and education, support of mothers and health care providers with breastfeeding information, education and a statewide 24 hour 7 day a week breastfeeding hotline, Fetal and Infant Mortality Review (FIMR) projects and Maternal Mortality Review (MMR); adolescent pregnancy prevention efforts; childhood injury prevention; school health to include funding of school nurses in priority areas of the state; Oklahoma's Poison Control Center; public education; and, data matching and analysis. Medicaid administrative match funds are received to support FIMR, MMR and data matching and analysis.

State funds, Medicaid funds and Title X federal funds support the provision of family planning services through county health departments and contract clinic sites. These funds are also used to provide a variety of educational programs targeted at decreasing unintended pregnancies; postponing sexual activity in teens; prevention of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV); and, increasing knowledge of human sexuality. Within the federal funds received are specific funds to support special projects in Oklahoma and Tulsa counties targeting the African American population in efforts to impact access to services, use of services and significant disparities in infant mortality rates. These funds are being used to accomplish family planning outreach and education and provision of clinical services.

Budget Documentation:
Overall budget preparation and monitoring are provided through administrative support within the OSDH Administrative Services. Agency budgeting, grants and contract acquisition staff meet routinely with program areas to assure program financial awareness. The MCH Chief is responsible for budget oversight and the Chief along with each individual Division Director is responsible for compliance with program standards and federal and state requirements.

The OSDH receives an annual independent audit of program and financial activities. The state's Office of the State Auditor and Inspector conducts this annual statewide single audit. The OSDH maintains an internal audit staff that reviews county health departments and subcontractors for compliance with contract fiscal matters relating to OSDH support. This staff reports directly to the Commissioner of Health. Additionally, MCH performs onsite program reviews with county health departments and contractors to assure programmatic compliance for both Title V and Title X.

The comptroller for the Family Support Services Division prepares and oversees the budget for the CSHCN Program. The CSHCN Director is responsible for compliance with federal and state requirements. CSHCN program staff monitor the budget and meet regularly to insure financial awareness within each budgeted area. CSHCN performs yearly onsite reviews with each

contracted entity to insure program compliance. Each contractor also undergoes an independent audit. The state's Office of the State Auditor and Inspector conducts an annual audit of the CSHCN Program to assure compliance and accountability.

The Title V Grant application documents a proposed budget on Forms 2, 3, 4 and 5 inclusive of Title V federal funds, state dollar match and anticipated income to be received from Medicaid. This budget is the base for services at the beginning of the grant period. As the year passes, the OSDH makes available more state and local funded resources (e.g., staff, supplies, travel) for provision of MCH services as an Agency priority. This results in increased funding reported as expended on Forms 3, 4 and 5. It is understood each year that these additional state and local funded resources are fluid and may be redirected at anytime by the Commissioner of Health based on state and/or agency priorities, or in the event of a state health event or emergency/disaster needing to be addressed.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.